

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10520

Reg. Dist. No.

CERTIFICATE OF DEATH

10551

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 9023 - 49th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Joseph	Middle M	Lost Angelico	4. DATE OF DEATH Sept. 22 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 10, 1894	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Pressman		10b. KIND OF BUSINESS OR INDUSTRY Gov't Printing		11. BIRTHPLACE (State or foreign country) Italy	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emanuel Angelico		14. MOTHER'S MAIDEN NAME Mary Maria Pizzimenti			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		INFORMANT Ruth Angelico, Wife Same	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 260X 1 week					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic coronary artery disease 4 years					
DUE TO (c) Diabetes Mellitus 4 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/14 , 1959, to 9/22 , 1959, that I last saw the deceased alive on 9/22 , 1959, and that death occurred at 11:45 PM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) COLLEGE PARK, Md					
DATE SIGNED 9/23/59					
ACTUAL SIGNATURE Louis Mendel					
M.D. 4506 COLLEGE AVE					
PHYSICIAN'S NAME (Type) Dr. C.L.Mendel		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cem.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/1959		22d. LOCATION (City, town, or county) Arlington, Virginia	
(State)					
23. FUNERAL DIRECTOR'S SIGNATURE W.W.Chambers Co., Riverdale, Md.					
ADDRESS					
24a. REC'D BY REGISTRAR DATE SEP 28 '59					
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

CHARGE TO STATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10521

10608

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Charles</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wood Brandywine</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		d. STREET ADDRESS <i>08X-2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brandywine Waldorf Clinic</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>WINFORD</i>	Middle <i>PRESTON</i>	Last <i>Banks</i>	4. DATE OF DEATH <i>Sept. 23 1959</i>	Month <i>Sept.</i>	Day <i>23</i>	Year <i>1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-26-1910</i>	9. AGE (In years last birthday) <i>49 yrs.</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bartender</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOTEL</i>		11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>UNKNOWN</i>		16. SOCIAL SECURITY NO. <i>579-87-6649</i>		INFORMANT <i>M. Ralph Brown Waldorf, Md.</i>		Address <i>10miles</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		my cardiac insufficiency				INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>General Cancer</i>		myocardial infarction						
(c) DUE TO <i>Unknown</i>		Cancer						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>at work</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Stephens Hill</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>9-9</i> , 19 <i>59</i> , to <i>9-23</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9-23</i> , 19 <i>59</i> , and that death occurred at <i>Stephens Hill</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Stephens Hill</i>		
ACTUAL SIGNATURE <i>Richard H. Dobson</i>		M.D.				DATE SIGNED <i>Stephens Hill</i>		
PHYSICIAN'S NAME (Type) <i>Richard H. Dobson</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/25/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Stephens Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Stephens Hill</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard H. Dobson</i>		ADDRESS <i>Stephens Hill</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6901 Avon St.		d. STREET ADDRESS 6901 Avon St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DORA	First MIDDLE BATEMAN	4. DATE OF DEATH Sept. 28th	Month Day Year 19 59
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.12.1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willis		14. MOTHER'S MAIDEN NAME Mary. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert. F. Bateman.		Address 6901. Avon. St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Coronary Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Coronary</i> (c) <i>Heart Disease</i> 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1125</i> , 19 <i>55</i> , to <i>9/28</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/28</i> , 19 <i>59</i> , and that death occurred at <i>845PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William Brainerd M.D.</i>		ADDRESS (Street, city or town, state) <i>6124 Central Ave</i> DATE SIGNED <i>9/28/59</i>	
PHYSICIAN'S NAME (Type) <i>WM BRAINARD</i>		<i>Capitol Hts Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9.30.59	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington.National		22d. LOCATION (City, town, or county) Arlington. Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24a. REC'D BY REGISTRAR DATE SEP 30 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10523

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived; If institution, Residence before admission) o. STATE	
Prince Georges MARYLAND		Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Takoma Park	11 years	17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
6703 Cockeryville Avenue		6703 Cockeryville Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Thomas	Last Bern
4. DATE OF DEATH	Month September	Day 3,	Year 1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-22-1916
9. AGE (in years at birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
43 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Manager Service station		Service Station Washington, D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Walton Bern		Marie Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT	
		578-05-5500 Marjorie Bern; same address as # 2.	
Address		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Strangulation	
974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (b) Hanging	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging. Suicide	
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> 5.00 p.m. 9-3-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) (County) (State) Takoma Park Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED Sept. 3, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-8-59	
		22c. NAME OF CEMETERY OR CREMATORIAL NATH MEM CEM	
		22d. LOCATION (City, town, or county) (State) FAIR CHURCH Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS 1400 Chapin St. N.W.	
		24a. REC'D BY REGISTRAR DATE SEP 8 '59	
		24b. REGISTRAR'S SIGNATURE Albert & Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WICHITA COUNTY GOVERNMENT CENTER
P.O. BOX 1300
WICHITA FALLS, TEXAS 76304-1300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon in papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10524

10610

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 8 MOS 17 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle M	Last BLAKE JR
4. DATE OF DEATH	Month SEPTEMBER	Day 25	Year 1959
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 MAY 18
9. AGE (In years last birthday) 41 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN	11. KIND OF BUSINESS OR INDUSTRY USAF	12. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME CHARLES M BLAKE SR	14. MOTHER'S MAIDEN NAME DECEASED		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 1941 TO DATE	INFORMANT OFFICIAL RECORDS	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EDEMA DUE TO (c) CHRONIC PANCREATITIS DUE TO (d) CHOLANGITIS DUE TO INTERVAL BETWEEN ONSET AND DEATH 12 HOURS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 18 months 18 months 48 HOURS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JANUARY 8, 1959 , to SEPTEMBER 25, 1959 , that I last saw the deceased alive on SEPTEMBER 25, 1959 , and that death occurred at 6:15A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>James M. Thompson</i> M.D. USAF HOSPITAL ANDREWS Sept 25, 59			
PHYSICIAN'S NAME (Type) JAMES M THOMPSON MAJOR USAF MC	USAF HOSPITAL ANDREWS, ANDREWS AFB, MD		
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/59	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State) Oil City, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Rinaldi</i>	ADDRESS Rinaldi Funeral Home, Inc. Washington, D.C.	24a. REC'D BY REGISTRAR DATE SEP 29 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Rinaldi</i>

CHARGEABLE TO DEPARTMENT

01801

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film G-249 10/1/59.cae

CERTIFICATE OF DEATH

16525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		10552 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Prince George</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale, Md.</i>		c. LENGTH OF STAY IN lb <i>28 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>4310 Jefferson St.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial Hosp.</i>				d. STREET ADDRESS <i>Bethesda</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mildred Viola</i>		First	Mid	Last	4. DATE OF DEATH <i>Sept 24 1959</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 27 1908</i>		9. AGE (In years last birthday) <i>50 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>South Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		
13. FATHER'S NAME <i>Harry Haliburton</i>				14. MOTHER'S MAIDEN NAME <i>Emma ?</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>503-18-1130</i>		17. INFORMANT <i>Hosp. records</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>416X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>		20f. (City or town) <i>Riverdale, Md.</i>	(County) <i>Riverdale, Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Sept 23</i> , 1958, to <i>Sept 24</i> , 1959, that I last saw the deceased alive on <i>Sept 23</i> , 1959, and that death occurred at <i>Riverdale, Md.</i> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>Riverdale, Md.</i>								
DATE SIGNED <i>9-24-59</i>								
ACTUAL SIGNATURE <i>L W Malin</i>		PHYSICIAN'S NAME (Type) <i>L W Malin</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/26/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Krause</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10553

CERTIFICATE OF DEATH

Reg. Dist. No.

10526

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland		c. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 22½ hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 5406 Gallatin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle E	Last Brenner	4. DATE OF DEATH	Month Sept	Day 13	Year 1959
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12 1875		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility Man		10b. KIND OF BUSINESS OR INDUSTRY Hechts		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ed Brenner				14. MOTHER'S MAIDEN NAME Mary Virginia Dare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Alice Brenner, Wife		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO <i>Cerebral Vascula Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Alleviation</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 days 10/4/59							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/11/59 , to 9/13/59 , at 3:40 P.M. What I last saw the deceased alive on Sept 13, 1959 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cheverly Md. DATE SIGNED 9/13/59							
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		Cheverly Md.			
PHYSICIAN'S NAME (Type) Dr. J. Kehoe				Cheverly Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STANLEY PARK - VICTORIA, BRITISH COLUMBIA

1960 - 1961 - 1962 - 1963 - 1964

1965 - 1966 - 1967

1968 - 1969

1970 - 1971

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10527

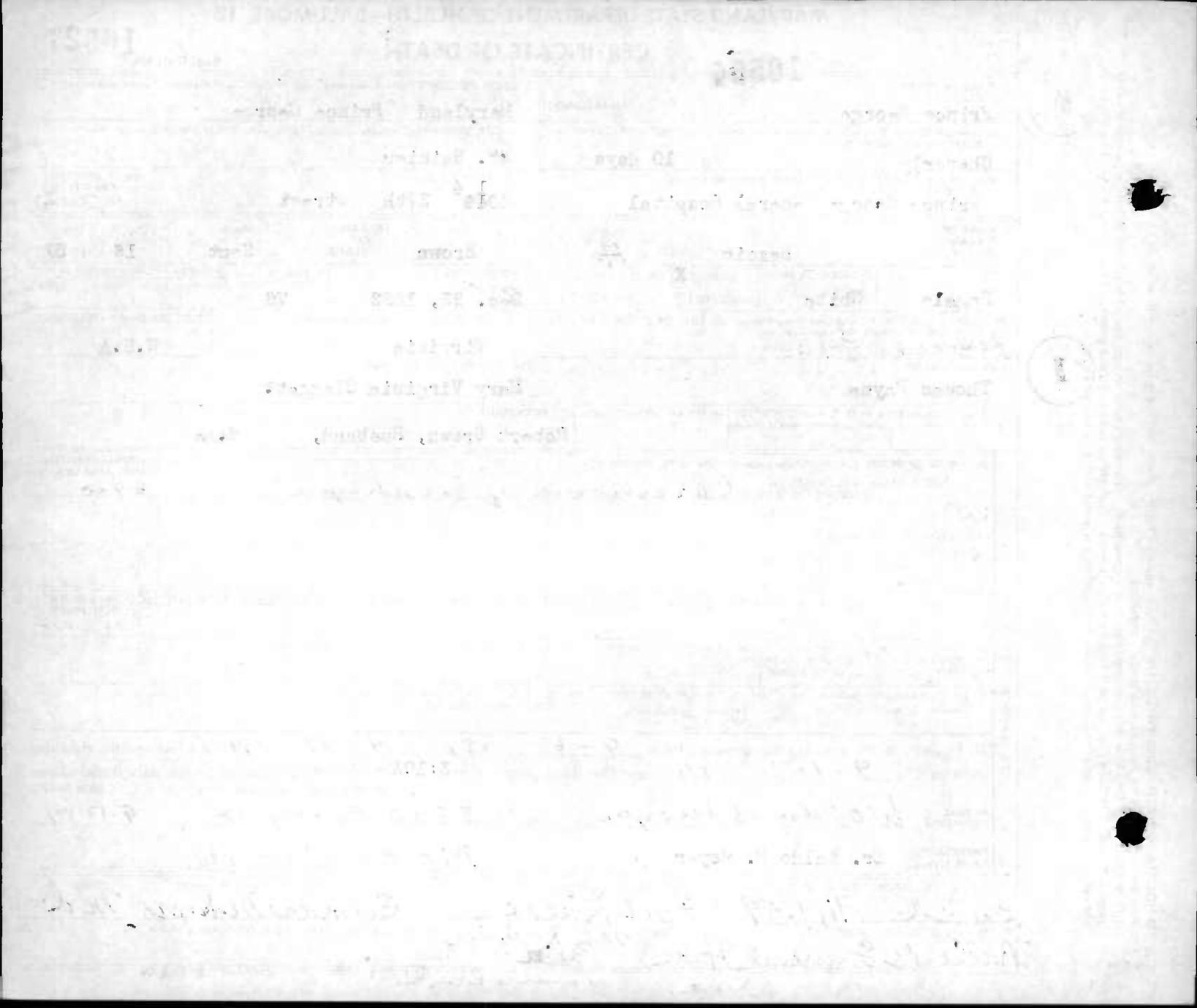
Reg. Dist. No.

10554

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier		d. STREET ADDRESS 4014 37th Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Bessie		First A.	Middle H.	Last Brown	4. DATE OF DEATH Sept 16 1959	Month Sept	Day 16	Year 1959
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH See Sec. 23, 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76		IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Payne				14. MOTHER'S MAIDEN NAME Mary Virginia Claggett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Robert Brown, Husband,		Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus DUE TO 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH 6 mo								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9 - 6 , 19 59 , to 9 - 17 , 19 59 , that I last saw the deceased alive on 9 - 16 , 19 59 , and that death occurred at 3:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Waldo B. Moyer M.D. 3503 Perry St 9-17-59								
DATE SIGNED								
ACTUAL SIGNATURE Dr. Waldo B. Moyer		PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/59		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		ADDRESS Mr. Rainier		24a. REC'D BY REGISTRAR RECEIVED SEP 21 '59		24b. REGISTRAR'S SIGNATURE Clinton & Knott		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10611

CERTIFICATE OF DEATH

Reg. Dist. No.

10528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON	c. LENGTH OF STAY IN 1b 6 mos.	b. COUNTY P. GEO.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CLINTON
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6643 TEMPLE HILLS RD.	d. STREET ADDRESS 6637 TEMPLE HILLS RD.		
3. NAME OF DECEASED (Type or print) BESSIE LEE	First F	Middle L	Last BROWN
4. DATE OF DEATH SEPT. 24 1959	Month SEPT.	Day 24	Year 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 4-1875
9. AGE (In years lost/birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME BRUCE BELL	14. MOTHER'S MAIDEN NAME FRANCES DOWNS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT SON-JOHN R. BROWN	Address 6641 TEMPLE HILLS RD. CLINTON
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO 422.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MULTIPLE MINOR CEREBRAL-VASCULAR ACCIDENTS DUE TO (c) ARTERIO SCLEROTIC CARDIAC VASCULAR DIS. 10 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour None			
20d. INJURY OCCURRED While at work Not white			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None			
20f. (City or town) (County) (State) None			
21. I certify that I attended the deceased from SEPT. 16, 1959 , to Present , that I last saw the deceased alive on SEPT. 16, 1959 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Arthur Shaver Jr. M.D. Branch Ave. Clinton, Md. 9/24/59			
DATE SIGNED Arthur Shaver Jr. M.D. Branch Ave. Clinton, Md. 9/24/59			
ACTUAL SIGNATURE ARTHUR SHAVER JR.			
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. BRANCH AVE. CLINTON MD. 9/24/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/26/59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) P. Geo. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc. 517-114 W. SE Wash. A.C.		24a. REC'D BY REGISTRAR Chamberlain & Son	24b. REGISTRAR'S SIGNATURE Chamberlain & Son
		DATE SEP 28 '59	

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG248 9-18-59 et

10529

10612

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X University Park				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4221 Sheridan St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 4221 Sheridan St.				
3. NAME OF DECEASED (Type or print)	First Richard	Middle Franklin	Last Bullock	4. DATE OF DEATH	Month September	Day 10, 1959	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> August 2, 1904	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teller, Foreign Ex.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard Edmund Bullock			14. MOTHER'S MAIDEN NAME Emma Mae Mervine					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT D.R. Purdie, M.D.		Address Riverdale, Md. 4404 Queensbury Rd.,		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary site colon DUE TO 5 yrs.</p> <p>DUE TO (c) Primary site colon DUE TO approx. 9 mo</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9-4 , 19 59 , to 9-10 , 19 59 that I last saw the deceased alive on 9-10 , 19 59 , and that death occurred at 100 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED				
ACTUAL SIGNATURE D.R. Purdie		M.D.		4404 Queensbury Rd.		9-10-59		
PHYSICIAN'S NAME (Type) D.R. Purdie, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sep 14, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10530

10613

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 21 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 1 Box 263		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle JEROME	Last BURCH
4. DATE OF DEATH	Month SEPT.	Day 12	Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 26, 1905
9. AGE (In years lost birthday) yrs. 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER	11. KIND OF BUSINESS OR INDUSTRY PLUMBING	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES BURCH	14. MOTHER'S MAIDEN NAME MARY THOMPSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 577-05-6293	17. INFORMANT WIFE - Florence Burch	Address Rt. Box 263 Clinton Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INANITION DUE TO (c) BRONCHIOGENIC CARCINOMA with generalized metastases DUE TO (d) NONE DUE TO (e) None DUE TO (f) None DUE TO (g) None DUE TO (h) None DUE TO (i) None DUE TO (j) None DUE TO (k) None DUE TO (l) None DUE TO (m) None DUE TO (n) None DUE TO (o) None DUE TO (p) None DUE TO (q) None DUE TO (r) None DUE TO (s) None DUE TO (t) None DUE TO (u) None DUE TO (v) None DUE TO (w) None DUE TO (x) None DUE TO (y) None DUE TO (z) None DUE TO (aa) None DUE TO (bb) None DUE TO (cc) None DUE TO (dd) None DUE TO (ee) None DUE TO (ff) None DUE TO (gg) None DUE TO (hh) None DUE TO (ii) None DUE TO (jj) None DUE TO (kk) None DUE TO (ll) None DUE TO (mm) None DUE TO (nn) None DUE TO (oo) None DUE TO (pp) None DUE TO (qq) None DUE TO (rr) None DUE TO (ss) None DUE TO (tt) None DUE TO (uu) None DUE TO (vv) None DUE TO (ww) None DUE TO (xx) None DUE TO (yy) None DUE TO (zz) None DUE TO (aa) None DUE TO (bb) None DUE TO (cc) None DUE TO (dd) None DUE TO (ee) None DUE TO (ff) None DUE TO (gg) 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MATERIALS AND EQUIPMENT OF HEALTH—BALTIMORE, MD

CERTIFICATE OF DEATH

Date of Death:

Name of Hospital or Institution: BALTIMORE CITY HOSPITAL
Address: 500 E. 33rd Street

Name of Physician:

Signature of Physician:

Title:

Address:

City:

State:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10531

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		10555 Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		o. STATE Maryland b. COUNTY Howard	
XXXXX Riverdale		D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				XXXXX Jessup XXXXXX 13x-2	
LeLand Memorial Hospital				d. STREET ADDRESS % Marybo Inn Restaurant	

3. NAME OF DECEASED (Type or print)	First Betty	Middle Lois	Last Burt	4. DATE OF DEATH	Month September	Day 27	Year 19 59
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5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-11-19	35 40 yrs.	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress	Restaurant	Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Murray	Della Semonis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	229-24-5647	Ralph Murray; Box 244, Laurel, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X		Hemorrhage and shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO Crushed chest
DUE TO (c)		Automobile accident
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with another auto.				
20c. TIME OF INJURY Month, Day, Year Hour 20 m. 2.00 p.m. 20 - 27 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Near Laurel, Howard	(County) Maryland	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>John T. Maloney</i>	DATE SIGNED
EXAMINER'S NAME (Type) John T. Maloney, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/59	22c. NAME OF CEMETERY OR CREMATORIAL Meadavidge Mem Park	22d. LOCATION (City, town, or county) Laurel Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Donaldson, Laurel, Md</i>	ADDRESS <i>Arthur & Kline</i>	24a. REC'D BY REGISTRAR DATE OCT 1 '59	24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BY BROWNING—ADDED TO PREVIOUS STATEMENT
HAD TO BE ADDED A MILEAGE CHART.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10532

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Forest	c. LENGTH OF STAY IN lb 2½ mon	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Forest	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8019 Barlowe Road		d. STREET ADDRESS 8019 Barlowe Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harvey Neale Byrd	First	Middle	Last
4. DATE OF DEATH September 23	Month	Day	Year 19 59
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-23
9. AGE (In years Incl/birthday) 36 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Machinery	11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Thomas Byrd		14. MOTHER'S MAIDEN NAME Addie Timmions	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. W.W.2	17. INFORMANT Doris Jean Byrd; same address as # 2.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock			INTERVAL BETWEEN ONSET AND DEATH
DUE TO 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of chest			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound.		
20c. TIME OF INJURY Month, Day, Year Hour 11.45 p.m. 9-23-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Kent Forest (County) Pr. Geo. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 23, 1959		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-25-59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.		ADDRESS	24a. REC'D BY REGISTRAR SEP 25 1959
			24b. REGISTRAR'S SIGNATURE <i>John T. Maloney</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10533

10556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

36 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE

Maryland

b. COUNTY

Prince Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cedar Heights

d. STREET ADDRESS

901 64th Ave.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Amy

Carroll

Sept.

25

19

59

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

Black

WIDOWED DIVORCED

May

9. AGE (In years
lost birthday)

79 yrs.

10. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Housewife

Maryland

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

George Johnson

Serena Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

INFORMANT

Address

Maggie Iverson

1226 G Street, N.E. Wash; D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

Pulmonary edema

INTERVAL BETWEEN
ONSET AND DEATH

4 days

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Atherosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes Mellitus

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Aug 21, 1959, to Sept 26, 1959, that I last saw the deceased alive on Sept 25, 1959, and that death occurred at 2:45 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D. 30 Ridge Rd., Greenbelt, Maryland

PHYSICIAN'S
NAME (Type) Dr. Hans Wodak22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
9/30/59

22c. NAME OF CEMETERY OR CREMATORIUM

Carroll Chapel

22d. LOCATION (City, town, or county)
Mitchellville

Prince George Co., Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR
DATE SEP 30 '59

24b. REGISTRAR'S SIGNATURE

1028

elterns

schule

Segundo Moreira

police

la

10534

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10557

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland		b. COUNTY Prince Georges					
Cheverly		D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		15 Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Prince Georges General Hospital		5504 43rd Place									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Kathryn Elizabeth Clarke					9-16-59			19			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Female	white	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	7-30-83	76 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Missouri			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ???????? Parsons			14. MOTHER'S MAIDEN NAME Laura Perkins			Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT							
No		213-40-5459		Jessie M Weaver; 45 Tudor City Place, N.Y. City							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure											
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED September 17, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/18/59		22c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Crematory		22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE <i>C. G. Sch. Koenig</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10535

Reg. Dist. No.

10558			
1. PLACE OF DEATH o. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs	
3. NAME OF -DECEASED (Type or print)		First DALE	Middle DEAN
		Last COFFMAN	4. DATE OF DEATH Sept. 9
		Month Day	Year 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Feb. 28, 1936	
9. AGE (In years from birthday) 23 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Sand & Gravel	11. BIRTHPLACE (State or foreign country) West Virginia
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor Coffman		14. MOTHER'S MAIDEN NAME Marian Dean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Edna L. Southard Address Same as # 2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution INTERVAL BETWEEN ONSET AND DEATH			
914.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Electrocuted while using a steam pressure cleaner on a loader	
20c. TIME OF INJURY Month, Day, Year How 4:00 p.m. 9-9- 1959		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) sand and gravel pit, Silver Hill Pr. Geo. Md.
20f. (City or town) Sutton		(County) MD	
		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John J. Maloney</i>		DATE SIGNED September 9, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill
		22d. LOCATION (City, town, or county) Sutton	
		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sennons Bros.</i>		ADDRESS 1661 - Good Hope Rd SE Wash 20052	24a. REC'D BY REGISTRAR Arthur & Thrua
		DATE SEP 14 '59	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10538 CERTIFICATE OF DEATH

Reg. Dist. No. **10536**

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.		c. LENGTH OF STAY IN 1b 3 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bells Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Md.	
3. NAME OF DECEASED (Type or print) Tad		4. STREET ADDRESS # 3 Pooks Hill Road	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/18/59	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 10 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D. C. U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benson L Cohen		14. MOTHER'S MAIDEN NAME Estelle K. Resnick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Benson L Cohen		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mongolism DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Birth			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/27 , 19 59 , to 8/27 , 19 59 , that I last saw the deceased alive on 8/27 , 19 59 , and that death occurred at 7:54 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Thomas A Chantreer M.D.			
DATE SIGNED 9/28/59			
ACTUAL SIGNATURE Thomas A Chantreer		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/28/59	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) (State)	
Fort Lincoln Crematory		Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR Arthur R. Kraus		24b. REGISTRAR'S SIGNATURE Arthur R. Kraus	
DATE SEP 29 '59			

86601

PHASO STADIUM

26201

1960-1961

Part I

26201

1960-1961
PHASO STADIUM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10559

CERTIFICATE OF DEATH

Reg. Dist. No.

10537

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b adm. 10-14-1940 Baltimore								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		e. STREET ADDRESS 2125 N. CABVERT ST.								
3. NAME OF DECEASED (Type or print) ANNA AUGUSTA COPPIER		4. DATE OF DEATH Month Sept Day 5 Year 1959	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept - 25 - 1864 94							
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. KIND OF BUSINESS OR INDUSTRY None	12. BIRTHPLACE (State or foreign country) NEW YORK	13. CITIZEN OF WHAT COUNTRY? U.S.A.					
14. FATHER'S NAME Simeon Brady		15. MOTHER'S MAIDEN NAME — ? STEELE		16. SOCIAL SECURITY NO. HOSPITAL RECORDS LAUREL SANITARIUM						
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Myocardial degeneration 422 MANY years						
19. MEDICAL CERTIFICATION		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral arterio sclerosis		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Laurel	(County) Baltimore	(State) Maryland
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>Sept - 5 - 1959</u> , that I last saw the deceased alive on <u>Sept - 5 - 1959</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.		ACTUAL SIGNATURE <u>John P. Kremer</u> M.D.		ADDRESS (Street, city or town, state) LAUREL SANITARIUM		DATE SIGNED 9-5-59				
22. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8/59		22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Memorial Park		22d. LOCATION (City, town or county) Baltimore		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Directors		24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arvin & Krause		ADDRESS 4101 Edmondson Ave.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

4
FOR STATE
HEALTH DEPT.

is necessary,
please exec. the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral Director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PAM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11694

1. PLACE OF DEATH
e. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince Georges General Hospital

3. NAME OF
DECEASED
(Type or print)

Jessie Robertson

First Middle

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

e. STATE

Maryland

b. COUNTY

Pr.Geo.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

15 Hyattsville

d. STREET ADDRESS

5027 37th Avenue

Last

Month

Day

Year

4. DATE
OF
DEATH

Sept.

6

1959

8. DATE OF BIRTH

5-14-1900

9. AGE (In years
last birthday)

59

yrs.

IF UNDER 1 YEAR

Months

Deys

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

11b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Robertson

14. MOTHER'S MAIDEN NAME

Jessie M. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or date of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

James E. Conaway; same address as #2.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemorrhage and shock

INTERVAL BETWEEN
ONSET AND DEATH

9040

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Spontaneous intracranial hemorrhage and

DUE TO

(c)

Hemorrhage due to fall in the home.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY
PERFORMED?
YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fall in the home

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 11:00 9-3- 59

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) Hyattsville, Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

September 6, 1959

Address (Street, city, town, or county)

ACTUAL
SIGNATURE

John J. Maloney

EXAMINER'S
NAME (Type)

John T. Maloney, M.D.

22e. BURIAL, CREMATION,
REMOVAL (Specify)

cremation

22b. DATE THEREOF

9-9-59

22c. NAME OF CEMETERY OR CREMATORIUM

Ft. Lincoln Crematorium

22d. LOCATION (City, town, or country)

Prince George, Maryland

(State)

23. FUNERAL DIRECTOR

Deal Funeral Home

ADDRESS

4812 Gr. Ave.

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE OCT 19 '59

Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

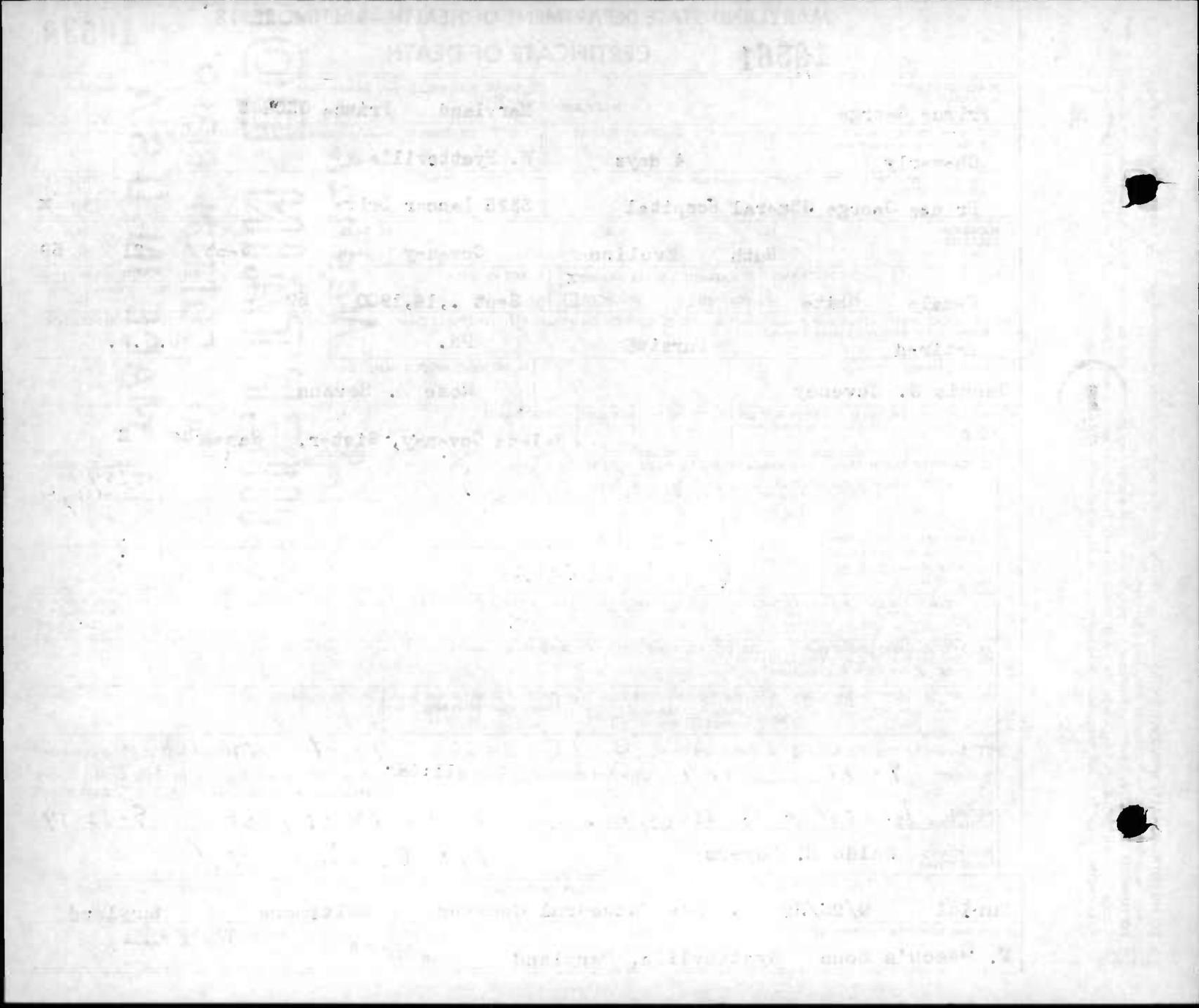
10561

CERTIFICATE OF DEATH

10538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital						d. STREET ADDRESS 3325 Lancer Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth Eveline Coveney		First	Middle	Last	4. DATE OF DEATH Sept 21 1959	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14, 1900		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dennis J. Coveney				14. MOTHER'S MAIDEN NAME Rose E. Bevans					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT Helena Coveney, Sister,		Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia (c) Uremia DUE TO Nephrosclerosis (c) 5 days									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 3503 Perry St		(County) Mt. Rainier Md	(State) 9-22-59
21. I certify that I attended the deceased from 3-15 , 19 53 , to 9-21 , 19 59 that I last saw the deceased alive on 9-21 , 19 59 , and that death occurred at 11:45P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 3503 Perry St Mt. Rainier Md									
DATE SIGNED 9-22-59									
ACTUAL SIGNATURE Waldo B. Moyers									
PHYSICIAN'S NAME (Type) Waldo B. Moyers									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/59		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR SEP 28 '59		24b. REGISTRAR'S SIGNATURE John & Anna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10615

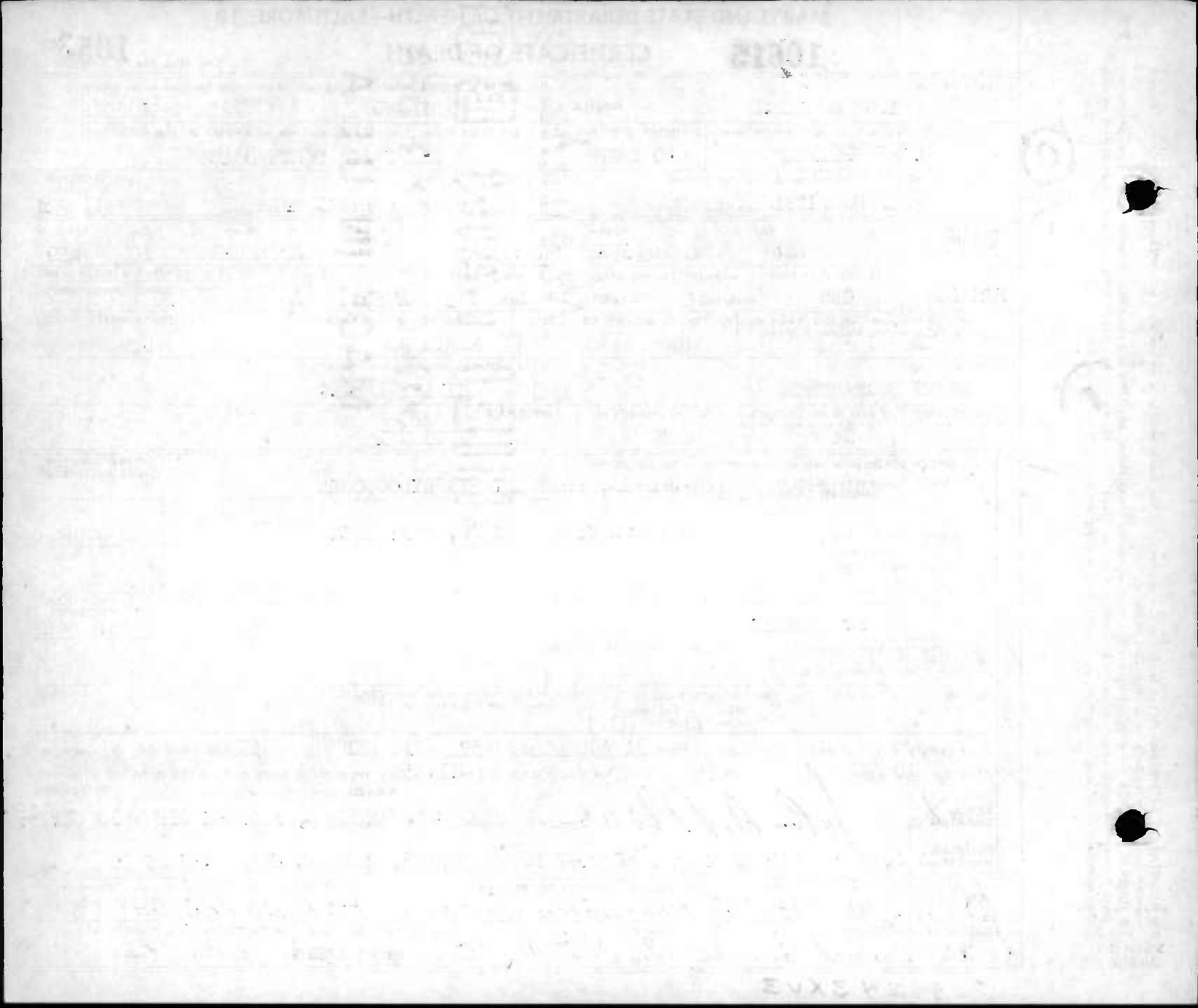
CERTIFICATE OF DEATH

Reg. Dist. No.

10539

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS	c. LENGTH OF STAY IN 1b 10 DAYS	b. COUNTY PRINCE GEORGES	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS	d. STREET ADDRESS USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANN MARGUERITE CRABTREE	First ANN	Middle MARGUERITE	Last CRABTREE	4. DATE OF DEATH SEPTEMBER 10 1959	Month SEPTEMBER	Day 10	Year 1959	
S. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 31, 1959	9. AGE (In years last birthday) NA yrs.	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Days 10	Hours Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA	10b. KIND OF BUSINESS OR INDUSTRY NA	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME ARVIN D CRABTREE	14. MOTHER'S MAIDEN NAME SHIRLEY A LOWE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NA	INFORMANT SEE SECTION 13	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, PROBABLY STAPHYLOCOCCAL								
692.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) STAPHYLOCOCCAL ABSCESS, LEFT KNEE								
48 HOURS								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PREMATURITY								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) 11:45A	(County) 10 SEP	(State) 1959		
21. I certify that I attended the deceased from 31 AUG , 1959, to 10 SEP , 1959, that I last saw the deceased alive on 10 SEP , 1959, and that death occurred at 11:45A , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) John A. Moore						DATE SIGNED 10 SEP 59		
ACTUAL SIGNATURE X								
PHYSICIAN'S NAME (Type) JOHN A. MOORE CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC								
22b. BURIAL, CREMATION, REMOVAL (Specify) CREMATION SEPT. 14, 1959	22c. DATE THEREOF SEPT. 14, 1959	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) ARLINGTON Va. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Insaldi Funeral Home, Inc.	ADDRESS 816 N St. NE, DC	24a. REC'D BY REGISTRAR SEP 14 '59	24b. REGISTRAR'S SIGNATURE Charles J. Krause					



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10540

10562		Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Prince Georges			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 N. Brentwood							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 3907 Wallace Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida Belle Culley		First Ida	Middle Belle	Last Culley	4. DATE OF DEATH September 13, 1959	Month September	Day 13	Year 1959			
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-27-18		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY U.of Md.		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME George Powell			14. MOTHER'S MAIDEN NAME Ida Watkins								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-2201		17. INFORMANT Samuel Culley; 1507 52nd Ave, Beaver Hts., Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure											
421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Valvular Heart Disease											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Washington, D.C. (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John T. Maloney</i>										DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-18-59		22c. NAME OF CEMETERY OR CREMATORIAL WOODLAWN		22d. LOCATION (City, town, or county) WASHINGTON, D.C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS ADDRESS 653 1432 You St. N.W.											
24a. REC'D BY REGISTRAR SEP 16 '59											
24b. REGISTRAR'S SIGNATURE <i>Caroline G. Kline</i>											

BY JONATHAN STAFFORD THE NEW YORK TIMES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10541

10563

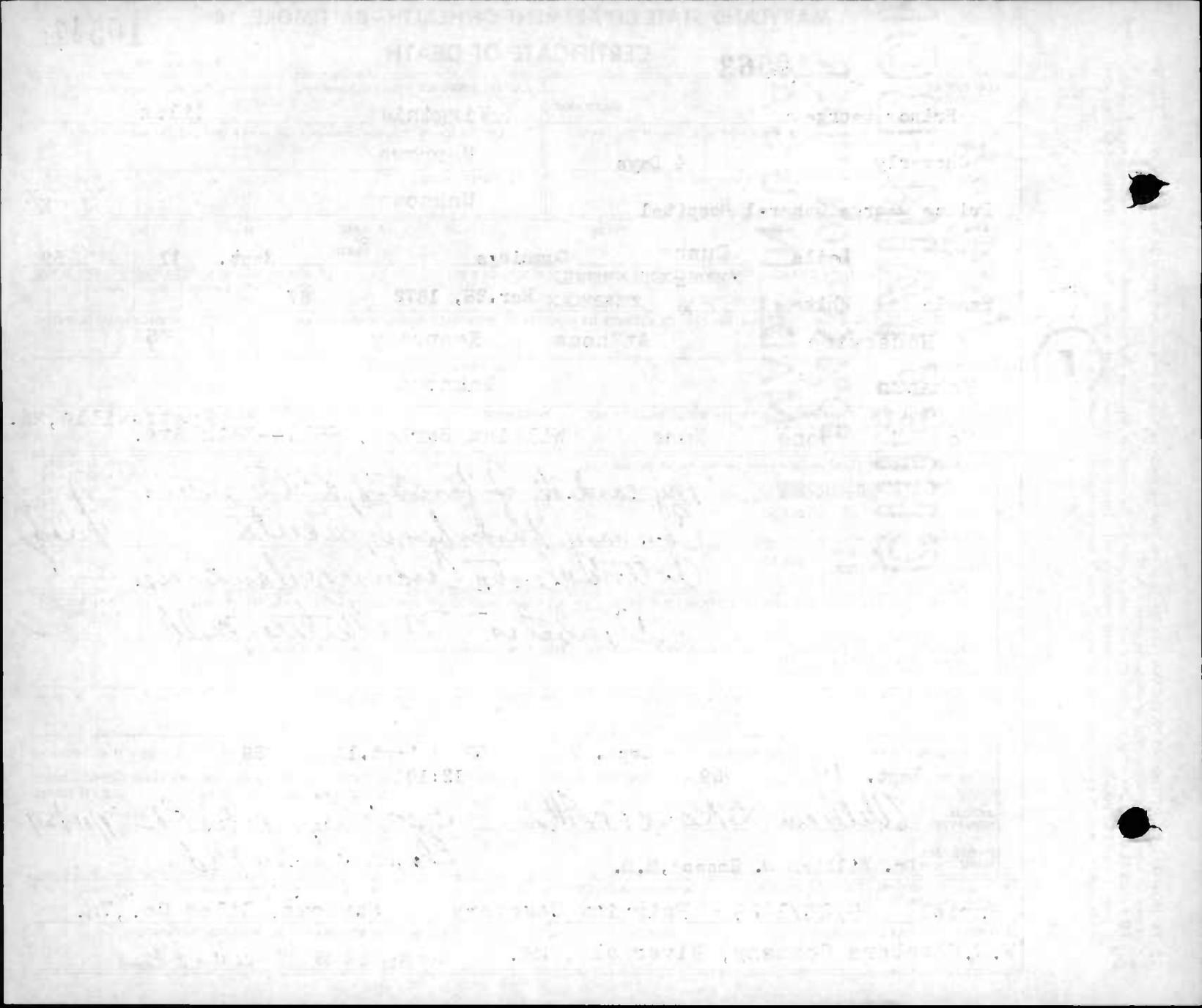
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Narrows	
3. NAME OF DECEASED (Type or print) Leila Dunn Cummings		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) Leila Dunn Cummings		4. DATE OF DEATH Sept. 11 1959	Month Day Year
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 28, 1872	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
10c. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Barker, 5511--38th Ave.		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
<i>Myocardial Infarction, acute anterior 4 days</i> <i>Coronary Thrombosis, acute 4 days</i> <i>Atherosclerotic Cardiovascular Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes Mellitus mild			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 7, 1959 , to Sept. 11, 1959 , that I last saw the deceased alive on Sept. 10, 1959 , and that death occurred at 12:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Rosson, M.D.		ADDRESS (Street, city or town, state) 5304 Campfield Rd. Bladensburg Md.	
DATE SIGNED 9/11/59			
PHYSICIAN'S NAME (Type) Dr. William D. Rosson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/1959	
22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Narrows, Giles Co., Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10542

10615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale			c. LENGTH OF STAY IN 1b 8 years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4906 Russell Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Avondale		
3. NAME OF DECEASED (Type or print) James Emmett Davis			4. DATE OF DEATH September 29 1959		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-18-92		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Owen Davis	
14. MOTHER'S MAIDEN NAME Ellen Mary Tyson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-3391	
17. INFORMANT Shirley D. Robertson; Riverdale, Maryland		Address 6303 46th Avenue, Riverdale, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED Sept. 29, 1959			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 2, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	
22d. LOCATION (City, town, or county) (State) Bethesda Md.		24a. REC'D BY REGISTRAR Arthur J. Kline		24b. REGISTRAR'S SIGNATURE Arthur J. Kline	
23. FUNERAL DIRECTOR'S SIGNATURE Neaf Funeral Home 4812 Ga Ave NW					
VS. A15ME(S) 5M 9/55					

ST. GEORGE'S CATHOLIC CHURCH PARISH
HABERDASHERY & FURNITURE DEALERS

REGISTRATION NO. 1000

DATE 12. 1. 1907

DO. 1907 REG. NO.

REGISTRATION

REG. NO.

REGISTRATION

ST. GEORGE'S CHURCH

REGISTRATION NO.

REGISTRATION NO.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10543

Reg. Dist. No.

10564

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lorentville							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7816 Marlboro Pike							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Sarah Crimora		First Sarah	Middle Crimora	Last Davis	4. DATE OF DEATH Sept. 6, 1959	Month Sept.	Day 6	Year 1959			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 31, 1883		9. AGE (In years last birthday) 75 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME William Swartzel					14. MOTHER'S MAIDEN NAME Unbeknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT John H Davis			Address Grottoes Virginia		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease									INTERVAL BETWEEN ONSET AND DEATH		
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED Sept. 6, 1959									
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-1959		22c. NAME OF CEMETERY OR CREMATORIAL Theresa			22d. LOCATION (City, town, or county) Stanton Va				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Mattingly Wash DC</i>		ADDRESS 131-1124		24a. REC'D BY REGISTRAR DATE SEP 8 '59			24b. REGISTRAR'S SIGNATURE Arthur & Thomas				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10565 CERTIFICATE OF DEATH

10544

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.	
		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.	
2		<p>1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 days</p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital</p>	
		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X XXXXXXXX</p>	
		<p>3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year Joseph Elliott Dennis</p>	
		<p>5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) 10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 18 June 1901 58 yrs. Months Days Hours Min.</p>	
		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer 10b. KIND OF BUSINESS OR INDUSTRY Triangle Construction Co. 11. BIRTHPLACE (State or foreign country) Pennsylvania</p>	
		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>	
		<p>13. FATHER'S NAME Joseph Henry Dennis 14. MOTHER'S MAIDEN NAME Susan Elizabeth Elliott</p>	
		<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 17. INFORMANT Address WW II 225-07-3246 Corrine Dennis, Wife Same #2</p>	
		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Fulminant Coronary Artery Disease INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary Artery Selective HT died 3 years 10 days (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
MEDICAL CERTIFICATION		<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)</p> <p>Hour a. m. p. m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	
		<p>21. I certify that I attended the deceased from _____, 1956, to Sept 28, 1959, that I lost sight of the deceased alive on Sept 27, 1959, and that death occurred at 6:10 AM, from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE Dr. L.R. Levitsky, M.D. ADDRESS (Street, city or town, state) M.D. 3408 Rhode Island Ave. N.W. DATE SIGNED 9/28/59</p> <p>PHYSICIAN'S NAME (Type) Dr. L.R. Levitsky, M.D. 14th & 11th St. N.W. 9/28/59</p>	
		<p>22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 22d. LOCATION (City, town, or county) (State)</p> <p>Burial 10/2/59 Arlington Natl. Cem. Arlington, Virginia</p>	
		<p>23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE</p> <p>The S. H. Hines Co. - 2901 14th St. N.W. Washington, D.C. DATE SEP 30 '59 Arthur S. Hines</p>	

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb lifey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Jimmie's Fruit Stand		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Rt. 4				Month Day Year			

077

3. NAME OF DECEASED (Type or print)		First Patrick	Middle Wallace	Last Diggs	4. DATE OF DEATH September 20 1959	Month	Day	Year
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5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan., 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker	10b. KIND OF BUSINESS OR INDUSTRY Fruit stand	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Patrick Diggs	14. MOTHER'S MAIDEN NAME Louise West
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Louise Morris; 851 20th St., Washington, D.C.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock		
916.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Universal 2nd and 3rd degree burns of body		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in fruit stand.		
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20c. TIME OF INJURY Month, Day, Year 4:00 a.m. 9-19-59 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fruit stand	20f. (City or town) Upper Marlboro	(County) Pr. Geo.	(State) Md.
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21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED September 20, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) 9-23-59	22b. DATE THEREOF 9-23-59	22c. NAME OF CEMETERY OR CREMATORIALy	22d. LOCATION (City, town, or county) Upper Marlboro, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Fraziers Funeral Home</i>	ADDRESS 389-R. S. Ar. n. W.	24a. REC'D BY REGISTRAR DATE SEP 22 '59	24b. REGISTRAR'S SIGNATURE Arthur J. Traas
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10617

CERTIFICATE OF DEATH

Reg. Dist. No.

10546

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 3 HRS 15 MIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DRIFKE	Middle N/B	Last REILY
4. DATE OF DEATH	Month SEPTEMBER	Day 9	Year 1959
5. SEX FFM ALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 SEP 59
9. AGE (In years last birthday) yrs. 3	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 15	12. IF UNDER 24 HRS Hours 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA	10b. KIND OF BUSINESS OR INDUSTRY NA	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FREDERICK DRIFKE	14. MOTHER'S MAIDEN NAME SHIRLEY A WASHTAK		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NA	INFORMANT	Address
SEE SECTION 13			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY			
776X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 SEP 1959 , to 9 SEP 1959 , that I last saw the deceased alive on 9 SEP 1959 , and that death occurred at 1:28A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sanford L. Billet</i>		ADDRESS (Street, city or town, state) M.D. USAF HOSP. ANDREWS, ANDREWS AFB 9 SEP 59	
DATE SIGNED			
PHYSICIAN'S NAME (Type) SANFORD L BILLET CAPT USAF MC USAF HOSP ANDREWS AFB WASHINGTON 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9-9-59	22c. NAME OF CEMETERY OR CREMATORIUM D. C. Morgue	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE -----	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 11 '59	24b. REGISTRAR'S SIGNATURE <i>Christine & Thruas</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10567

CERTIFICATE OF DEATH

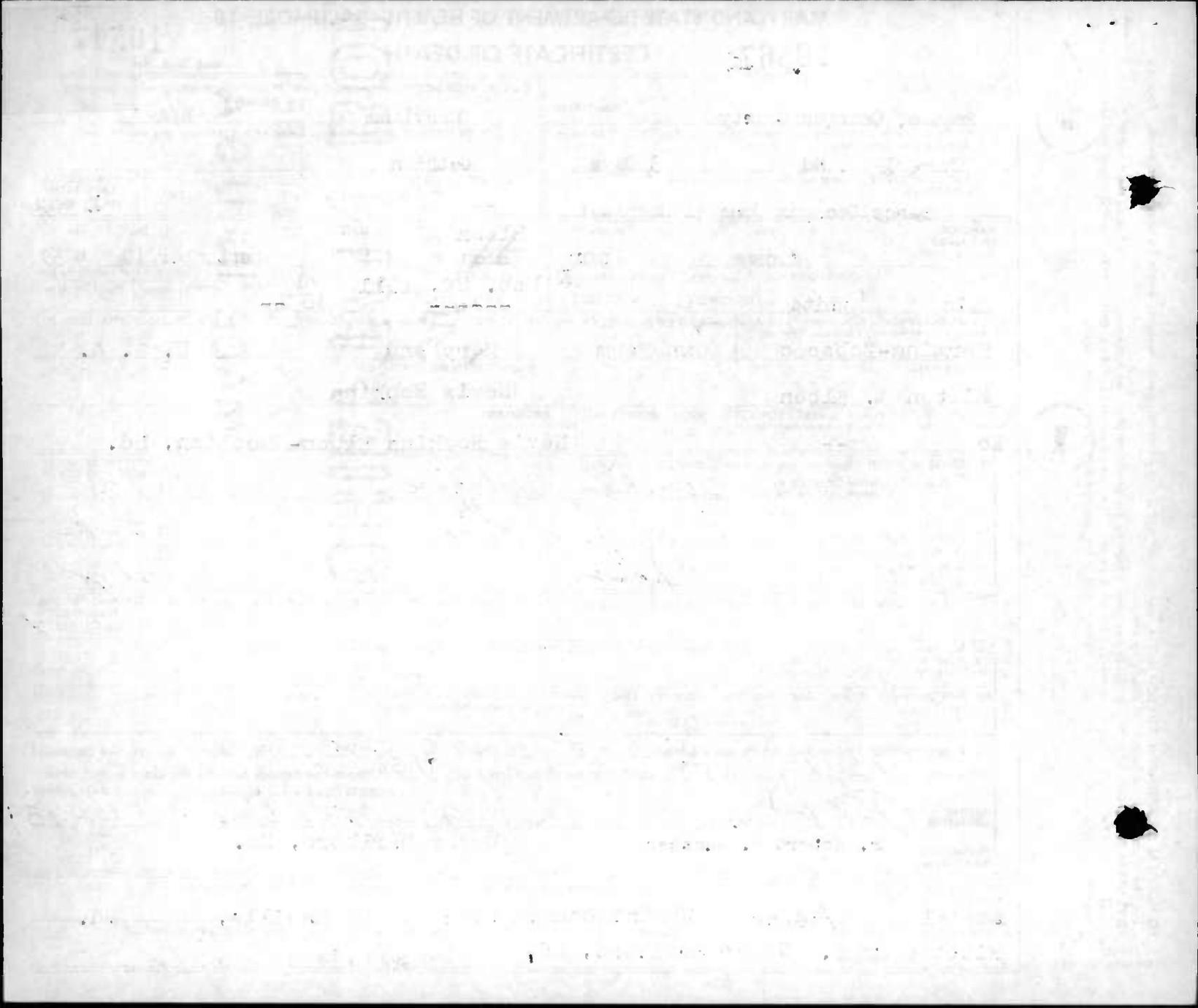
10547

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian		d. STREET ADDRESS 02X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		* *		
3. NAME OF DECEASED (Type or print) Eugene		First	Middle	Elben	4. DATE OF DEATH XXIX	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1911	9. AGE (In years last birthday) 48 10 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming-Tobacco		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Milton S. Elben		14. MOTHER'S MAIDEN NAME Nevia Hopkins						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		INFORMANT Nevia Hopkins Elben- Lothian, Md.		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 581.1</p> <p>DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) Circulatory Collapse</p> <p>DUE TO (c) Cirrhosis of Liver</p> <p>DUE TO (c) Alcoholism</p> <p>INTERVAL BETWEEN ONSET AND DEATH 1 mo.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/24/59 , 1959, to 10/5/59 , 1959, that I last saw the deceased alive on 10/5/59 , 1959, and that death occurred at 7/14/59 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 10/5/59						
ACTUAL SIGNATURE <i>Robert B. Sascer</i>		M.D. Upper Marlboro, Md. 10/5/59						
PHYSICIAN'S NAME (Type) Dr. Robert B. Sascer								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/59		22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cem.		22d. LOCATION (City, town, or county) (State) Owensville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		ADDRESS 24a. REC'D BY REGISTRAR DATE SEP 14 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Knapp						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10548

CERTIFICATE OF DEATH

Reg. Dist. No.

10618

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newton Village Md.	c. LENGTH OF STAY IN lb 12 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newton Village Md.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4916 Monroe Street.,	d. STREET ADDRESS 4916 Monroe Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Annie Middle Fierstein	4. DATE OF DEATH Sept. 20, 1959-	Month	Day Year				
S. SEX female white	6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY own Home	11. BIRTHPLACE (State or foreign country) Washington D. C.	12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME ? Roth	14. MOTHER'S MAIDEN NAME Johanna ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	INFORMANT Carl A. Fierstein	Address Newton Village, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Coronary Thrombosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hyattsville, Md.					
ACTUAL SIGNATURE Leonard Hays	DATE SIGNED 9/23/59						
POLICE PHYSICIAN'S NAME (Type) Leonard Hays	Hyattsville, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/23/59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Colmar Manor, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville, Maryland.	24a. REC'D BY REGISTRAR DATE SEP 23 '59	24b. REGISTRAR'S SIGNATURE Albert S. Kraus				

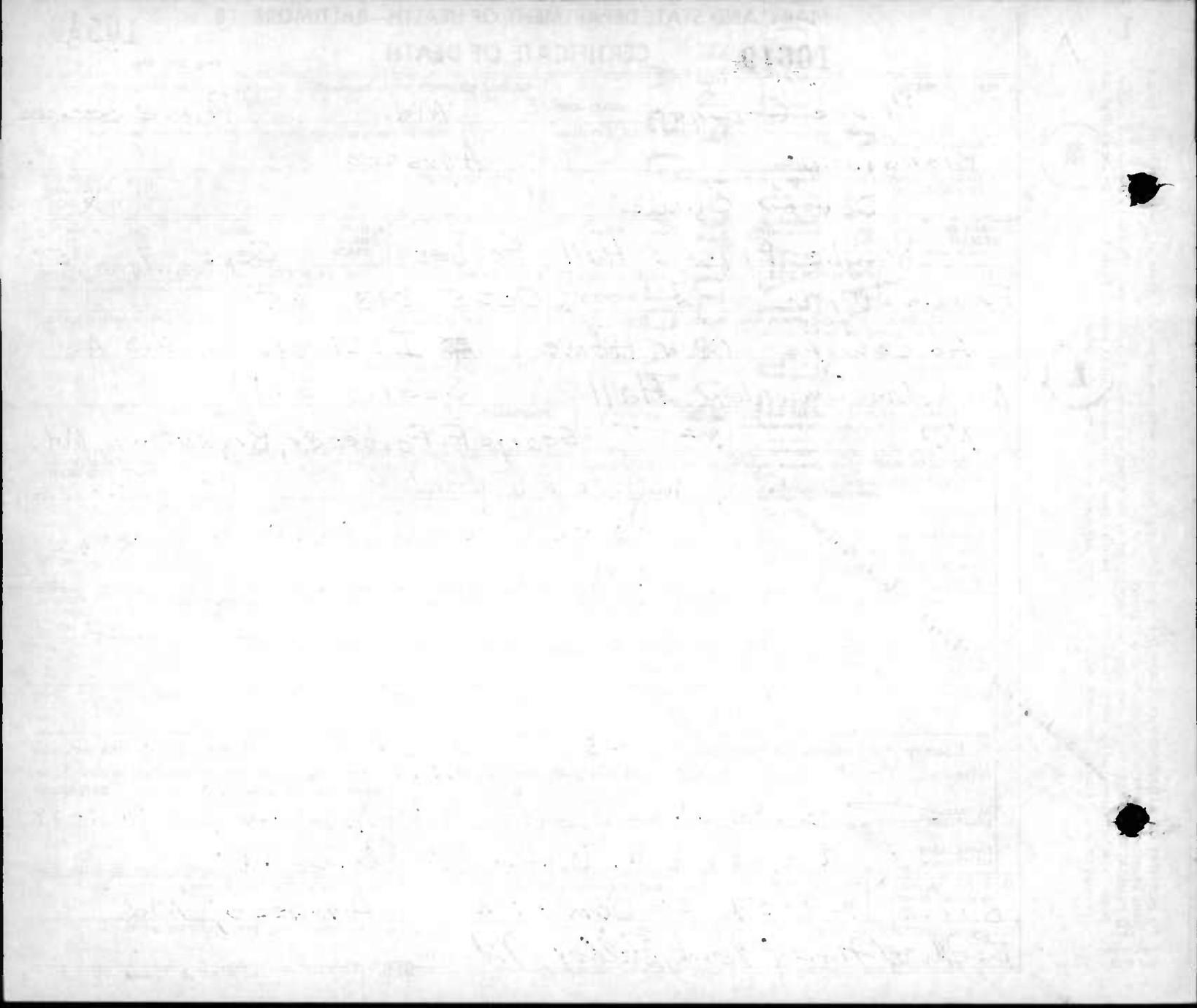
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574-9030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10549	
10619 CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brandywine</i>		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aquasco</i>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dobson Clinic</i>					d. STREET ADDRESS <i>/</i>						
3. NAME OF DECEASED (Type or print) <i>Rosalie Eugenia Hall Forbes</i>		First <i>Rosalie</i>	Middle <i>Eugenia</i>	Last <i>Hall Forbes</i>	4. DATE OF DEATH <i>Sept 7, 1959</i>		Month <i>Sept</i>	Day <i>7</i>	Year <i>1959</i>		
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 5, 1893</i>			9. AGE (In years last birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months <i>65</i>		IF UNDER 24 HRS. Days <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			11. BIRTHPLACE (State or foreign country) <i>ILLinois</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Nicholas Snowden Hall</i>					14. MOTHER'S MAIDEN NAME <i>Stella Gill</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>✓</i>			INFORMANT <i>George F. Forbes Jr, Bryantown, Md.</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Myocardial Infarction</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Normal cardio-vascular - Renal Disease</i> (c) <i>Atherosclerosis</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Bryantown</i>		(County) <i>Calvert Co.</i>		(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>9-5</i> , 19 <i>59</i> , to <i>9-7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9-7</i> , 19 <i>59</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <i>Bryantown, Md.</i>	
ACTUAL SIGNATURE <i>Richard H. Dobson</i>										DATE SIGNED <i>9-7-59</i>	
PHYSICIAN'S NAME (Type) <i>Richard H. Dobson</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-9-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Dominic's</i>				22d. LOCATION (City, town, or county) <i>Aquasco, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		ADDRESS <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>✓</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Hunt</i>		DATE <i>SEP 11 '59</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10550	
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital					d. STREET ADDRESS 4008 37 Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Randolph Forrest		First	Middle	Last	4. DATE OF DEATH Sept 2 19 59		Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/18			9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver			10b. KIND OF BUSINESS OR INDUSTRY retired			11. BIRTHPLACE (State or foreign country) Washington D. C.			12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Bladen Forrest					14. MOTHER'S MAIDEN NAME Henrietta Messinger						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. no			INFORMANT Helen Lambden Sister			Address 231-33St. NE Washington		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> 49IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Fatty metastasis ph. Rthm.</i> DUE TO (c) <i>Acute alcohol intoxication</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month	Day	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Aug 30 19 59 , to Sept 2 19 59 , that I last saw the deceased alive on Sept 2 19 59 , and that death occurred at 11:15P , from the causes and on the date stated above.					ADDRESS (Street, city or town, state) William D. Rosson M.D. 5304 Annapolis Road Bladensburg, Maryland DATE SIGNED 9/3/59						
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. William D. Rosson											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/59		22c. NAME OF CEMETERY OR CREMATORIUM Holy Rood Cemetery			22d. LOCATION (City, town, or county) Washington D. C. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE 1. Gasch's Sons Hyattsville, Md.					24a. REC'D BY REGISTRAR DATE SEP 8 '59					24b. REGISTRAR'S SIGNATURE Arthur & Evans	

• 10

• 9 •

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10551

10569

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey		b. COUNTY Camden	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pennsauken		d. STREET ADDRESS 2285 Hillcrest Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harvey L.	Middle	Last Gaumer	4. DATE OF DEATH	Month Sept.	Day 27	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 22 July 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Treasurer		10b. KIND OF BUSINESS OR INDUSTRY Dairy Co		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Gaumer		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. .		INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/18/61 , 19 59, to 9/22/59 , 19 59, that I last saw the deceased alive on 9/18/61 , 19 59, and that death occurred at 2:45 AM from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. Musser</i> ADDRESS (Street, city or town, state) 4410 74 Ave DATE SIGNED 9/27/59							
PHYSICIAN'S NAME (Type) Dr. F. Musser., M.D.		Bellmeade Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/59		22c. NAME OF CEMETERY OR X CEMETORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Pennsauken New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR Arthur K. Trahan		24b. REGISTRAR'S SIGNATURE Arthur K. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHARGE TO STATIONED

22-10

RECORDED BY: [Signature]

RECORDED BY:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

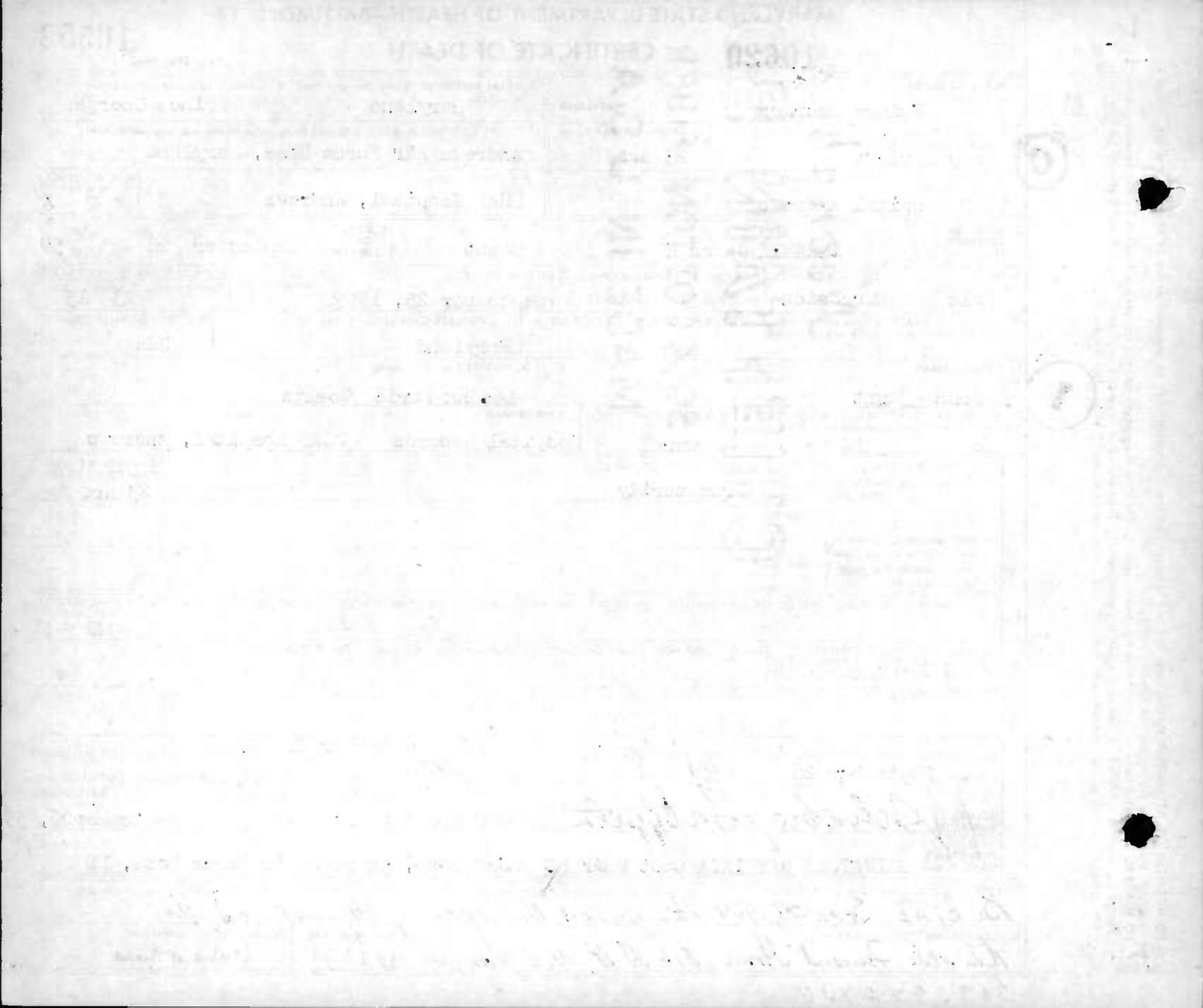
10620

CERTIFICATE OF DEATH

Reg. Dist. No.

10552

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN 1b 23 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Andrews Air Force Base, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS USAF Hospital, Andrews			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) James H		First	Middle	Last	4. DATE OF DEATH Month September Day 26 Year 19 59		
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 25, 1959	9. AGE (In years lost birthday) yrs. 23 Months 15 Hours 15 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Gaunt		14. MOTHER'S MAIDEN NAME LeeAnn Marie Voeltz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Hospital Records	Address USAF Hospital, Andrews		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 23 Hrs					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity							
776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sep 25 , 1959, to September 26, 1959 , that I last saw the deceased alive on September 26 , 1959, and that death occurred at 0200A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <i>Salvatore Battiata</i>		M.D. USAF Hospital Andrews September 26, 59					
PHYSICIAN'S NAME (Type) SALVATORE BATTIATA Capt USAF MC		USAF Hosp. Andrews Air Force Base, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF Sept. 29, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rimale Funeral Home</i>		ADDRESS 816 H St., N.E., WASH., DC.		24a. REC'D BY REGISTRAR SEP 29 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur & Thorne</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10553

Reg. Dist. No.

10570

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jonathon	Middle Frederick	Last Month Day Year Gehman Sept 5, 1959
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 4-5-19	9. AGE (In years (at birthday) 40 yrs.) IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post office	11. BIRTHPLACE (State or foreign country) Dist. of Columbia
13. FATHER'S NAME Arthur R. Gehman		14. MOTHER'S MAIDEN NAME Ida Frederick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Ida F. Gehman; 3708 40th Place, Cottage City, Mo
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure			
DUE TO 581.0			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of the liver			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney	DATE SIGNED Sept. 6, 1959		
EXAMINER'S NAME (Type) John T. Maloney, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-10-59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National	22d. LOCATION (City, town, or county) Ft Myer, Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home	ADDRESS Washington d.c.	24a. REC'D BY REGISTRAR SEP 8 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Trahan

X 1
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 X 2
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages X and 2 with the registrar prior to burial, cremation, or removal.

BT-BROWNSTEIN-1994-34 TO 7 拜訪個人個案訪談調查
- 請問該公司對其工作滿意嗎？請問該公司工作滿意嗎？

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 2 FilmG249 10-9-59 et 10539 CERTIFICATE OF DEATH										Reg. Dist. No. 10554					
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. Virginia					b. COUNTY Prince Georges Co.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			d. STREET ADDRESS Herndon		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Rest Home					4922 LaSalle Road R.F.D. #2					83X-3					
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle I.	Last GERNAND	4. DATE OF DEATH September 26 1959		Month September	Day 26	Year 1959						
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/74		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Examiner					10b. KIND OF BUSINESS OR INDUSTRY U.S. Patent Office		11. BIRTHPLACE (State or foreign country) Illinois			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Abraham H. Gernand					14. MOTHER'S MAIDEN NAME Emma Evans										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Decedent		Address --									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X <i>Bronchopneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Vascular thrombosis</i> DUE TO (c) <i>Cerebral Arterosclerosis</i>										INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease										7 days over 5 yrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1635 Mass. Ave. N.W. Wash. D.C.		(County) M.D.		(State) 9/26/59					
21. I certify that I attended the deceased from Jazz , 19 .58 , to Sept 26 , 19 .59 that I last saw the deceased alive on Sept 26 , 19 .59 , and that death occurred at 9-20A M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Louis H. Shuman					
ACTUAL SIGNATURE Louis H. Shuman										DATE SIGNED 9/26/59					
PHYSICIAN'S NAME (Type) Louis H. Shuman		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9/29/59								22b. DATE THEREOF 9/29/59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Kelle C. 2900 1st. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE SEP 30 '59								24b. REGISTRAR'S SIGNATURE Charles E. Evans					

100%

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10571

Item 12 Film G249 10-6-59 et

Reg. Dist. No.

1055

1. PLACE OF DEATH
a. COUNTY

Prince Georges MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly 33 days

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE New York b. COUNTY

New York

69 X 3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

930 East 4th Street

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Gilberto

Middle

Last

Granado

4. DATE
OF
DEATH

Month September Day 24, Year 1959

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

7-29-30

9. AGE (in years
last birthday)

29

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dish-washer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Santa Clara, Cuba

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Pastor Granado

14. MOTHER'S MAIDEN NAME

Dolores Portieres

Address

Felicidad Granado; same address as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pulmonary edema and congestion

INTERVAL BETWEEN
ONSET AND DEATH

816 X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

Cerebral necrosis (Right parietal temporal area)

DUE TO

(c)

Old subdural hematoma

2 MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

auto.

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Passenger in an automobile in collision with another /

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
2.45xxx 8-22-59

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

Mitchellville Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes , Accident Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

September 25, 1959

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)
(State)

New York, N.Y.

Removal

9-26-59

23. FUNERAL DIRECTOR & SIGNATURE

ADDRESS

Lee Funeral Homme Washington d.c.

24a. REC'D BY REGISTRAR
DATE SEP 29 '59

24b. REGISTRAR'S SIGNATURE

Arthur Kline

MANUFACTURED BY THE GOVERNMENT OF NEPAL - BUREAU OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

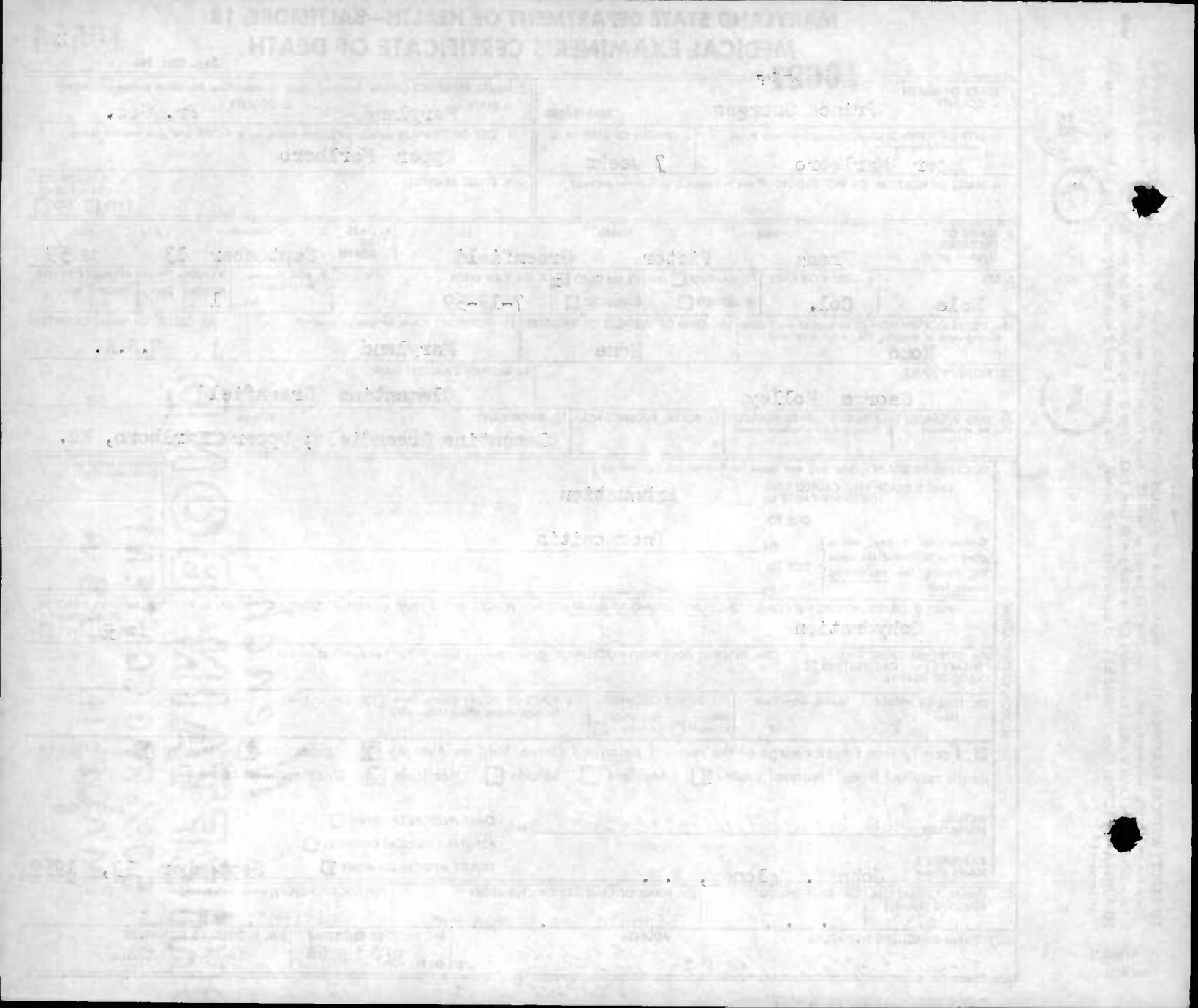
NAME OF DECEASED	SEX	AGE	DATE OF DEATH	TIME OF DEATH	CAUSE OF DEATH	DEATH CERTIFIED
NAME OF MEDI	RELATIONSHIP	ADDRESS	NAME OF HOSPITAL	NAME OF DOCTOR	NAME OF DOCTOR	NAME OF DOCTOR
REASON FOR DEATH						
EXAMINER'S SIGNATURE						

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 7 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Franz Victor Greenfield		First	Middle	Last	4. DATE OF DEATH September 13 1959	Month	Day	Year
S. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-19-59	9. AGE (In years last birthday) yrs. 1	IF UNDER 1YEAR Months 1	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME George Holley				14. MOTHER'S MAIDEN NAME Clementine Greenfield				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Clementine Greenfield; Upper Marlboro, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonitis (a), stating the underlying cause last. DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dehydration								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney	DATE SIGNED							
EXAMINER'S NAME (Type) John T. Maloney, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-16-59	22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Mem. Cemetery		22d. LOCATION (City, town, or county) Suitland, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert J. McGuire	ADDRESS 1870-9" NW	24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10572

CERTIFICATE OF DEATH

Reg. Dist. No.

10557

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake		c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Seat Pleasant		d. STREET ADDRESS 7106 F. Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle S.	Last Gregory	4. DATE OF DEATH Sept 17 1959	Month Sept	Day 17	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/9/78	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John. W. Gregory				14. MOTHER'S MAIDEN NAME Emma. M. Lacy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT John Gregory		Address Brother Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Coronary Thrombosis (c) DUE TO Decelerated Arteriosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2016-Prep St. Seat Pleasant Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept - 1, 1959 , to Sept 17, 1959 , that I last saw the deceased alive on Sept 17, 1959 , and that death occurred at 11:10P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Max M Herzberg							
PHYSICIAN'S NAME (Type) Dr. Herzberg							
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/21/59		22b. DATE THEREOF 9/21/59		22c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory		22d. LOCATION (City, town, or county) Wash D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home. 300 4th st N.E.				ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 22 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

RECEIVED IN THE LIBRARY OF THE UNIVERSITY OF TORONTO

SECTION OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10573

CERTIFICATE OF DEATH

Reg. Dist. No.

10558

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup,		13x-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		d. STREET ADDRESS 229 Mission Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Hager	4. DATE OF DEATH September 19 1959	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH September 19, 1959	9. AGE (In years last birthday) — yrs. 35	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Thomas Chester Hager		14. MOTHER'S MAIDEN NAME Phyllis Opal Pennington					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE Frank L. Weaver, M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) Frank L. Weaver, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) 9-19-59		22b. DATE THEREOF Hospital	22c. NAME OF CEMETERY OR CREMATORIALy	22d. LOCATION (City, town, or county) Laurel, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Laurel General Hospital, Laurel, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

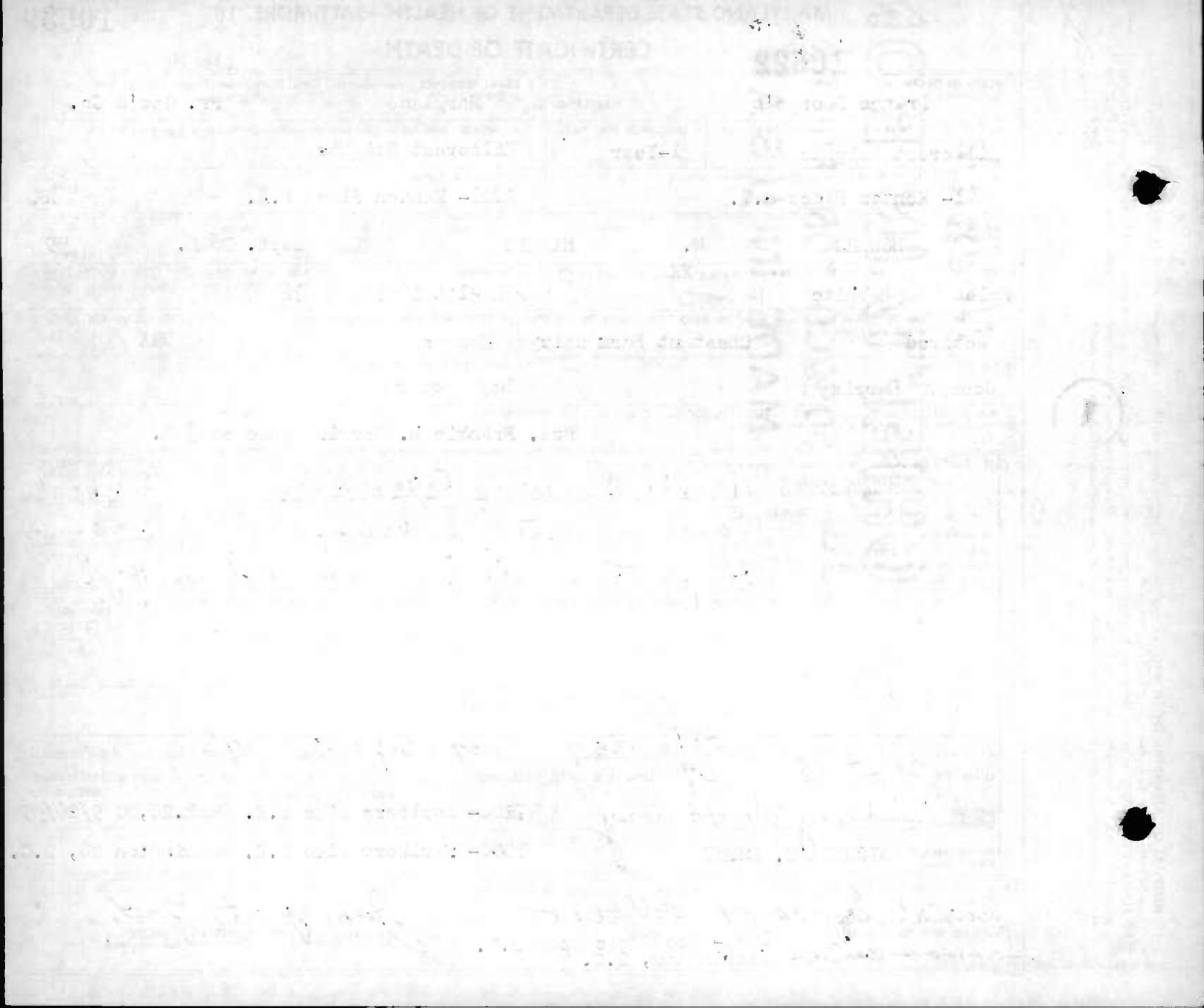
10559

10622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 1-Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hillcrest Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2021- Kenton Place S.E.				d. STREET ADDRESS / 2621- Kenton Place S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HOWARD	Middle M.	Last HARRIS	4. DATE OF DEATH	Month Sept. 26th.	Day Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 21st 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Chestnut Farm Dairy		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Harris				14. MOTHER'S MAIDEN NAME May Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Mrs. Frankie L. Harris Same as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Coronary artery sclerosis.</u> DUE TO (c) <u>Hypertensive arterio vascular disease</u> 10yr							
INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Manh. 19	Doy. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County) (State)
21. I certify that I attended the deceased from <u>Sept. 18</u> , 1957, to <u>Sept. 26</u> , 1959, that I last saw the deceased alive on <u>Sept. 18</u> , 1959, and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7200- Marlboro Pike S.E. Wash. 28, DC</u> 9/26/59							
DATE SIGNED <u>9/26/59</u>							
ACTUAL SIGNATURE <u>Sidney W. Lowry</u>							
PHYSICIAN'S NAME (Type) <u>SIDNEY W. LOWRY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Sept 30-59</u>		22b. DATE THEREOF <u>Sept 30-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Oddfellow</u>		22d. LOCATION (City, town, or county) <u>Jamesport Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brothers</u>		ADDRESS 1661- Good Hope Road S.E. Washington, D.C.		24a. REC'D BY REGISTRAR <u>SEP 28 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Simmons & Brothers</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10623 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince Georges MARYLAND		a. STATE Md.	b. COUNTY Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Lanham 84 yr.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Box 187	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt #1 Box 187		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Hawkins, Sr.		First	Middle
		Last	
4. DATE OF DEATH Sept. 2 1959		Month	Year
5. SEX Male Negro		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Sept. 8, 1874 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Hawkins		14. MOTHER'S MAIDEN NAME Nancy Guy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. If yes, give war or dates of service)	
17. INFORMANT Elizabeth G. Hawkins		Address Lanham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for, (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			
(b) Hypertension			
DUE TO (c) Generalized Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
6 yrs			
10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Henry A. Wise Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Henry A. Wise Jr.		DATE SIGNED Sept. 2, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 58	
22c. NAME OF CEMETERY OR CREMATORIAL Ascension Cemetery		22d. LOCATION (City, town, or county) Bowie, Pr. Georges, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE No Mortuary Service		ADDRESS 1820-9" WASH. DC. (1)	
24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Carla & Anna	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after this certificate has been signed by the attending physician and may be retained by the hospital or attending physician.

HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and may be retained by the hospital or attending physician.

This form should be detached for use as the "inter-funeral permit". Then please sign _____

O **HOSPITAL OR** **TO FUNERAL DIRECTOR**
A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9383

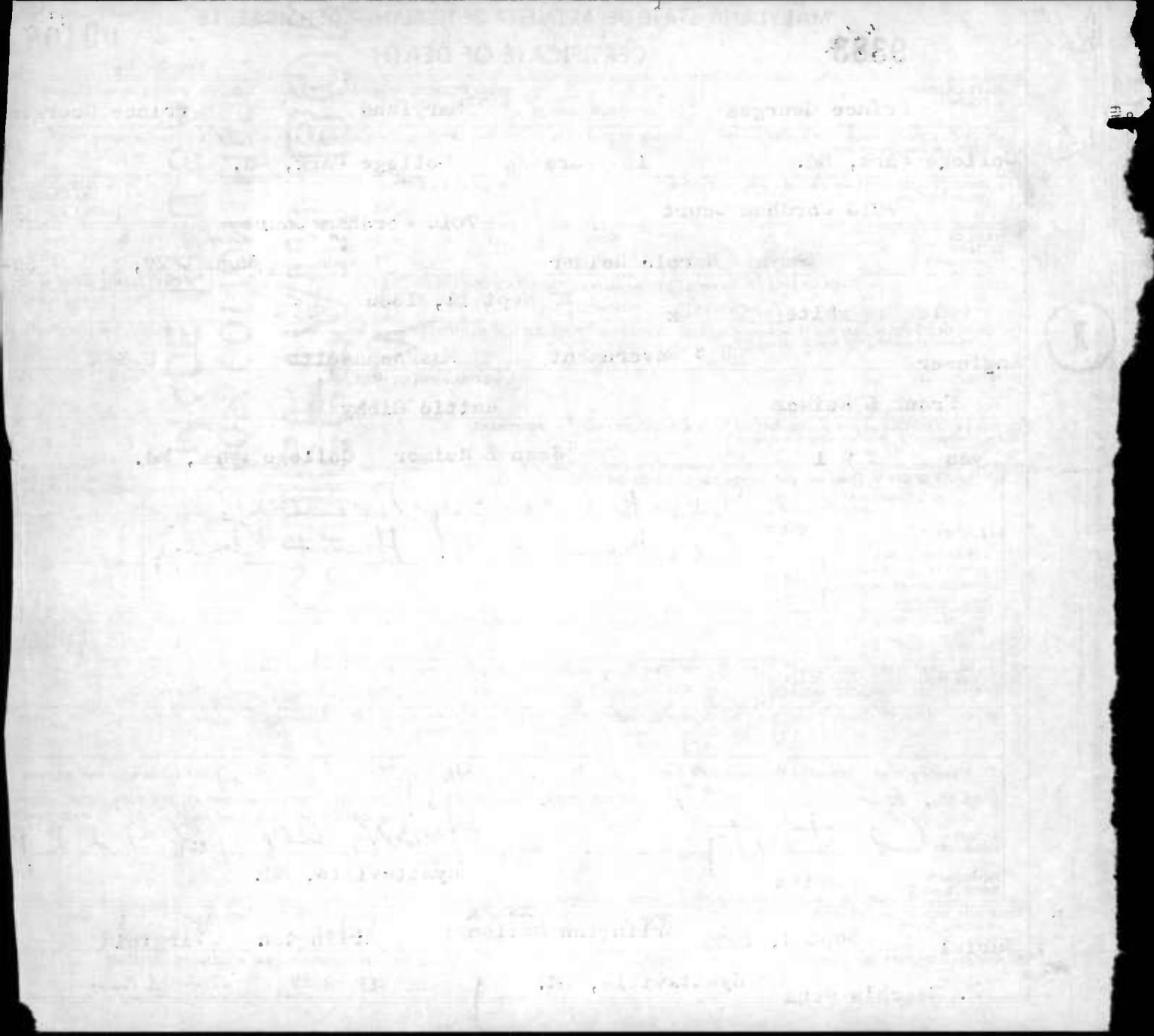
Item 4 Film G269 8-17-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

19498

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		c. LENGTH OF STAY IN 1b 18 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7015 Fordham Court		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.	
3. NAME OF DECEASED (Type or print) Paul Harold Heimer		First Paul	Middle Harold
4. DATE OF DEATH Sept. 20, 1959	Month Sept.	Day 20	Year 1959
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept 11, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank L Heimer		14. MOTHER'S MAIDEN NAME Hattie Gibby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W 1	
17. INFORMANT Jean E Heimer		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebral Hemorrhage (c) Arteriosclerotic Heart Disease			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-4 , 19 46 , to 9-1 , 19 59 that I last saw the deceased alive on 6-2 , 19 57 , and that death occurred at SP M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Deitz		ADDRESS (Street, city or town, state) Hyattsville, Md.	
PHYSICIAN'S NAME (Type) A Deitz		DATE SIGNED 9-2-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 4, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE SEP 4 '59
			24b. REGISTRAR'S SIGNATURE Arthur & Kraske



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10561

10540

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>6 mo. 200 days</i>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CARROLL MANOR 4922 LASALLE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47 X-3</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS <i>2120 16th ST. N.W.</i>					
3. NAME OF DECEASED (Type or print) <i>MARGARET</i>		First	Middle	Last	4. DATE OF DEATH <i>September 14th 1959</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Dec. 12 1898</i>	9. AGE (In years last birthday) <i>80 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Government Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington D.C. U.S.A.</i>	
13. FATHER'S NAME <i>John Hickay</i>		14. MOTHER'S MAIDEN NAME <i>Honora Cronin</i>		12. CITIZEN OF WHAT COUNTRY? <i>Barrett Manor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		INFORMANT <i>J.M. Joseph Bernadette, d. Cura.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Inanition</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Meth. State Co. of Pectum</i>				1-yr.	
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 14</i> , 19 <i>58</i> , to <i>Sept. 14</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Sept. 14</i> , 19 <i>59</i> , and that death occurred at <i>6:45 AM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>James J. Foster</i>		ADDRESS (Street, city or town, state) <i>1746 K St. N.W. Washington D.C.</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>James J. Foster</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-17-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Olivet Cemetery</i>	
22d. LOCATION (City, town, or county) <i>D.C.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis Collins</i>		ADDRESS <i>3821-14th St. N.W.</i>		24a. REC'D BY REGISTRAR <i>Sep 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>C. G. S. Kraus</i>

НРАВОВЫЙ СТАНДАРТ 1980

10562

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb ½ Hr.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen., Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Estelle Howard				4. DATE OF DEATH Sept. 8 Month Day Year 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 27, 1877	
9. AGE (In years (last birthday) 82 yrs.)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		11. KIND OF BUSINESS OR INDUSTRY Own Home		12. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Adaline White		15. CITIZEN OF WHAT COUNTRY? U.S.A.			
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. Unk.		18. INFORMANT Dorothy Mayo		19. ADDRESS 1315 Lincoln Ave. Cinn., Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 812X Hemorrhage and shock INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple fractures of legs and fractured							
DUE TO skull. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A pedestrian; struck by an automobile					
20c. TIME OF INJURY Hour 10.50 p.m. Month, Day, Year 9-7-1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Vista (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED Sept. 8, 1959			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-59		22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial		22d. LOCATION (City, town, or county) Suitland 020 (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS C. ADDRESS 800 1653 1432 You St. N.W.				24a. REC'D BY REGISTRAR DATE SEP 14 '59		24b. REGISTRAR'S SIGNATURE <i>Charles A. Hansen</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BY PROGRESSIVE-TECHNOLOGY LEADERSHIP
IN INTEGRATED DESIGN.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10541

CERTIFICATE OF DEATH

Reg. Dist. No.

10563

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Dr. Leo</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>same</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	c. LENGTH OF STAY IN lb <i>20 yrs</i>	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5704-31st Street</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X same</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. STREET ADDRESS <i>same</i>			
3. NAME OF DECEASED (Type or print) <i>John Pearce</i>	First <i>John</i>	Middle <i>Pearce</i>	Last <i>Howard</i>
4. DATE OF DEATH <i>Sept 30</i>	Month <i>Sept</i>	Day <i>30</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>ca</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 8, 1884</i>
9. AGE (In years lost birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>1</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caretaker</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Penns</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Frederick A Howard</i>	14. MOTHER'S MAIDEN NAME <i>Bessie Pearce</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>578-16-2262</i>	17. INFORMANT <i>Mrs. Jessie Howard</i>	Address <i>same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>420.0</i>			
DUE TO <i>De congestive heart failure</i>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <i>Arteriosclerotic heart Yes</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month <i>July</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>College Park Md</i>
20f. (City or town) <i>College Park</i>	(County) <i>Md.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Aug 6</i> , 1959, to <i>Sept 29</i> , 1959, that I last saw the deceased alive on <i>Aug 6</i> , 1959, and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.L. Etienne</i>	ADDRESS (Street, city or town, state) <i>4713 Berwyn Rd College Park Md</i>		
PHYSICIAN'S NAME (Type) <i>W.L. Etienne</i>	DATE SIGNED <i>9/30/59</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>9/30/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft Lincoln Crematory</i>	22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gasch's Sons</i>	ADDRESS <i>Hyattsville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>Oct 1 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Editor of House</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10564

1. PLACE OF DEATH a. COUNTY		10575		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges		MARYLAND		a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	Pr. Geo.
Riverdale		D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		15 Hyattsville		d. STREET ADDRESS	1 5714 Ager Road
Leland Memorial Hospital				e. IS RESIDENCE ON A FARM?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
Tina	Marie	Howey		September	29 1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
Female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-1-59	29	29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Charles Truitt Howey		Gladys Sines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Address	
				Charles T. Howey; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia					
492X DUE TO Acute pneumonitis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Hour o. m. p. m.		19			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE		John T. Maloney, M.D.			
EXAMINER'S NAME (Type)		DATE SIGNED			
		Sept. 29, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		10/1/59		Fort Lincoln	
22d. LOCATION (City, town) or county				(State)	
Colmar Manor				Ind	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Francis Gasoli Sons		Hyattsville Md		DATE OCT 1 '59	
24b. REGISTRAR'S SIGNATURE					
Cathleen S. Krause					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AT 3:00PM TUESDAY - MARCH 30 THE MICHIGAN STATE GUARDIAN
HAD TO STAY AWAY FROM MAXIE FADIEN.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10624

CERTIFICATE OF DEATH

Reg. Dist. No.

11728

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 6 mo, 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D.C.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Washington 47x-3	
3. NAME OF DECEASED (Type or print) Chester		4. DATE OF DEATH Month Day Year Sept. 30 1959	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/25/89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus Jefferson		14. MOTHER'S MAIDEN NAME Fannie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-6936	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 1 yr., 2 mo's			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/10/59 , to 9/30/59 , 1959, that I last saw the deceased alive on September 30, 1959 , and that death occurred at 10:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Moe Weiss</i>		ADDRESS (Street, city or town, state) M.D. Glenn Dale Hospital, Maryland DATE SIGNED 9/30/59	
PHYSICIAN'S NAME (Type) Moe Weiss			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/5/59.	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn	22d. LOCATION (City, town, or county) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Alexander S. Pope</i>		ADDRESS 414-15th, St SE	24a. REC'D BY REGISTRAR DATE OCT 8 '59
		24b. REGISTRAR'S SIGNATURE <i>Albert & Kraus</i>	

Janet

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10565

CERTIFICATE OF DEATH

Reg. Dist. No.

10576		CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Prince George					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b 26½ hours					b. COUNTY Prince George						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights					f. STREET ADDRESS 804 58 Ave.						
3. NAME OF DECEASED (Type or print) Raynar					4. DATE OF DEATH Sept 20 19 59					Month Sept Day 20 Year 19 59						
S. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/59			9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Dots Hours Min.			IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? United states	
13. FATHER'S NAME Richard Blake					14. MOTHER'S MAIDEN NAME Shirley Johnson											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					INFORMANT Shirley Mother					Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 DUE TO Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Inanition (c)																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																
INTERVAL BETWEEN ONSET AND DEATH																
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Hour a. m. p. m.		Month 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that I attended the deceased from Sept 19 19 59 to Sept 20 19 59 , that I last saw the deceased alive on Sept 20 19 59 , and that death occurred at 7:30P.M. from the causes and on the date stated above.																
ACTUAL SIGNATURE John Perkins Dr. John Perkins M.D										ADDRESS (Street, city or town, state) M.D. 5301 Hanover St., Agawam, MA 01001						
DATE SIGNED 9/19/59																
22a. BURIAL CREMATION OR REMOVAL (Specify) 9-25-59		22b. DATE THEREOF 9-25-59		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cem -		22d. LOCATION (City, town, or county) Bonney Rd 85, NC		(State)								
23. FUNERAL DIRECTOR'S SIGNATURE Henry L. Washington 467 N st NW					ADDRESS Henry L. Washington 467 N st NW					24a. REC'D BY REGISTRAR DATE SEP 24 '59		24b. REGISTRAR'S SIGNATURE John L. Trahan				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AMERICAN AIRLINES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10566

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	c. LENGTH OF STAY IN lb 8 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4230-34th Street-		d. STREET ADDRESS 14230-34th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle ISAAC	Last JONES
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5th, 1872
9. AGE (In years last birthday) 86 yrs.		Month Sept. 10th,	Day Year 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder & Contractor		10b. KIND OF BUSINESS OR INDUSTRY Homes, etc.	11. BIRTHPLACE (State or foreign country) Orange County, Va.
12. CITIZEN OF WHAT COUNTRY? USA		Address Montana Ave., N.E. Washington, D.C.	
13. FATHER'S NAME James M. Jones		14. MOTHER'S MAIDEN NAME Lucy Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT None 577-09-1476 Irene A. Garvey, 1500	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO <i>Cerebral Arterial Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) <i>Atherosclerotic Heart Disease</i> DUE TO } (c) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH 3 days years. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Augt 10</i> , 1959, to <i>9/10</i> , 1959, that I last saw the deceased alive on <i>Sept 10</i> , 1959, and that death occurred at <i>5:05 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 335-W--St. N.E. Washington, D.C.	
ACTUAL SIGNATURE <i>Charles V. Pate</i>		DATE SIGNED 9/10/1959	
PHYSICIAN'S NAME (Type) Charles V. Pate		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 9/14/1959		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland Rd. Pr. Geo. Co., Md. (State)		23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.	
24a. REC'D BY REGISTRAR SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
VS A1S (4) 1SM 9/55			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10577

CERTIFICATE OF DEATH

Reg. Dist. No.

10567

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Adelphi		d. STREET ADDRESS 8706 23rd Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle Paul	Last Kemerer	4. DATE OF DEATH Sept. 7 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1 Nov 1902	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William J. Kemerer		14. MOTHER'S MAIDEN NAME Matilda Hamilton		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		INFORMANT George Anna Kemerer (Wife)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 457X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
						<i>Caused by cerebral Cerebral Anemia Generalized arteriosclerosis.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 19 45 , to 9-7 , 19 59 , that I last saw the deceased alive on 9-7 , 19 59 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.						22. LOCATION (City, town, or county) Hyattsville (State) Maryland.	
ACTUAL SIGNATURE <i>A Deitz</i>		ADDRESS Hyattsville Md.		DATE SIGNED 9-7-59			
PHYSICIAN'S NAME (Type) A Deitz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/59		22c. NAME OF CEMETERY OR CREMATORIUM George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 11 '59		24b. REGISTRAR'S SIGNATURE <i>Living S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Q 8 3 205 (22) - 1968 April 20

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10578

CERTIFICATE OF DEATH

Reg. Dist. No.

10568

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 WEST HYATTSVILLE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S CO. HOSP.	d. STREET ADDRESS 5901- 33rd AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HERBERT	First	Middle D.	Last KETCHUM			
4. DATE OF DEATH	Month 9	Day 8	Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/96			
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years 1st birthday) 63 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store clerk Atchison & Keller		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington, D.C.			
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Eva T. Ketchum			
			Address same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.2</i> DUE TO <i>Sarcoma with metastasis</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO _____ (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>Aug. 1, 1957</i> to <i>9/12, 1959</i> , that I last saw the deceased alive on <i>9/12, 1959</i> , and that death occurred at <i>9:50 AM</i> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>R.S. Williams</i>	ADDRESS (Street, city or town, state) <i>35 New York Ave NW Washington DC</i>			DATE SIGNED <i>9/18/59</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/11/59	22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery	22d. LOCATION (City, town, or county) Washington, D.C.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS <i>2901 14th St. N.W. Washington 9, D.C.</i>	24a. REC'D BY REGISTRAR DATE SEP 10 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Name of Physician

Name of Hospital

Address of Hospital

City of Hospital

State or Province

Country

Post Office

County

NAME
DATE
HOSPITALNAME
ADDRESS
CITY

MURK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10569

10579

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4526 Banner St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Adelene	Middle	Last King	4. DATE OF DEATH	Month Sept.	Day 6	Year 19 59
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	b. DATE OF BIRTH Nov. 15 1918	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Sept.	IF UNDER 24 HRS. Days 6	Hours Min. 19 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House maid		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur King		14. MOTHER'S MAIDEN NAME Estelle Stewart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-34-3751		INFORMANT Estelle King, Prince Frederick, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561.2							
DUE TO Intestinal obstruction							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Incalcerated umbilical hernia							
DUE TO (c) 5 days							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary atelectasis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-27 , 19 59 , to 9-6 , 19 59 , that I last saw the deceased alive on 9-6 59 , 19 59 , and that death occurred at 7:30A M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 7220 Forest Road							
DATE SIGNED Kent Village, Md.							
ACTUAL SIGNATURE R. Kennedy Skipton M.D.		22a. BURIAL CREMATION, REMOVAL (Specify) 9-9-59					
PHYSICIAN'S NAME (Type) Dr Kennedy Skipton M.D.		22b. DATE THEREOF 9-9-59					
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive					
ADDRESS Prince Frederick		22d. LOCATION (City, town, or county) (State) Calvert Co. Md.					
24a. REC'D BY REGISTRAR DATE SEP 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knau					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10570

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1½ hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Tiawana	Middle Landis	4. DATE OF DEATH Month Day Year Sept 20 19 59
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mamie Landis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Grand-Mother Ethel Landis Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 571.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Entehocolitis (clinical) (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Nat while of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20 , 19 59 , to Sept 20 , 19 59 , that I last saw the deceased alive on Sept 20 , 19 59 , and that death occurred at 5P M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John S. Perkins</i> ADDRESS (Street, city or town, state) M.D. 5301 Hamilton St., Hyattsville DATE SIGNED 8/16/59 PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sep-24-1959	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.		ADDRESS 3015 12th St., N. E.	24a. REC'D BY REGISTRAR DATE SEP 23 '59
			24b. REGISTRAR'S SIGNATURE Arthur J. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 249 10-5-59 ams

10571

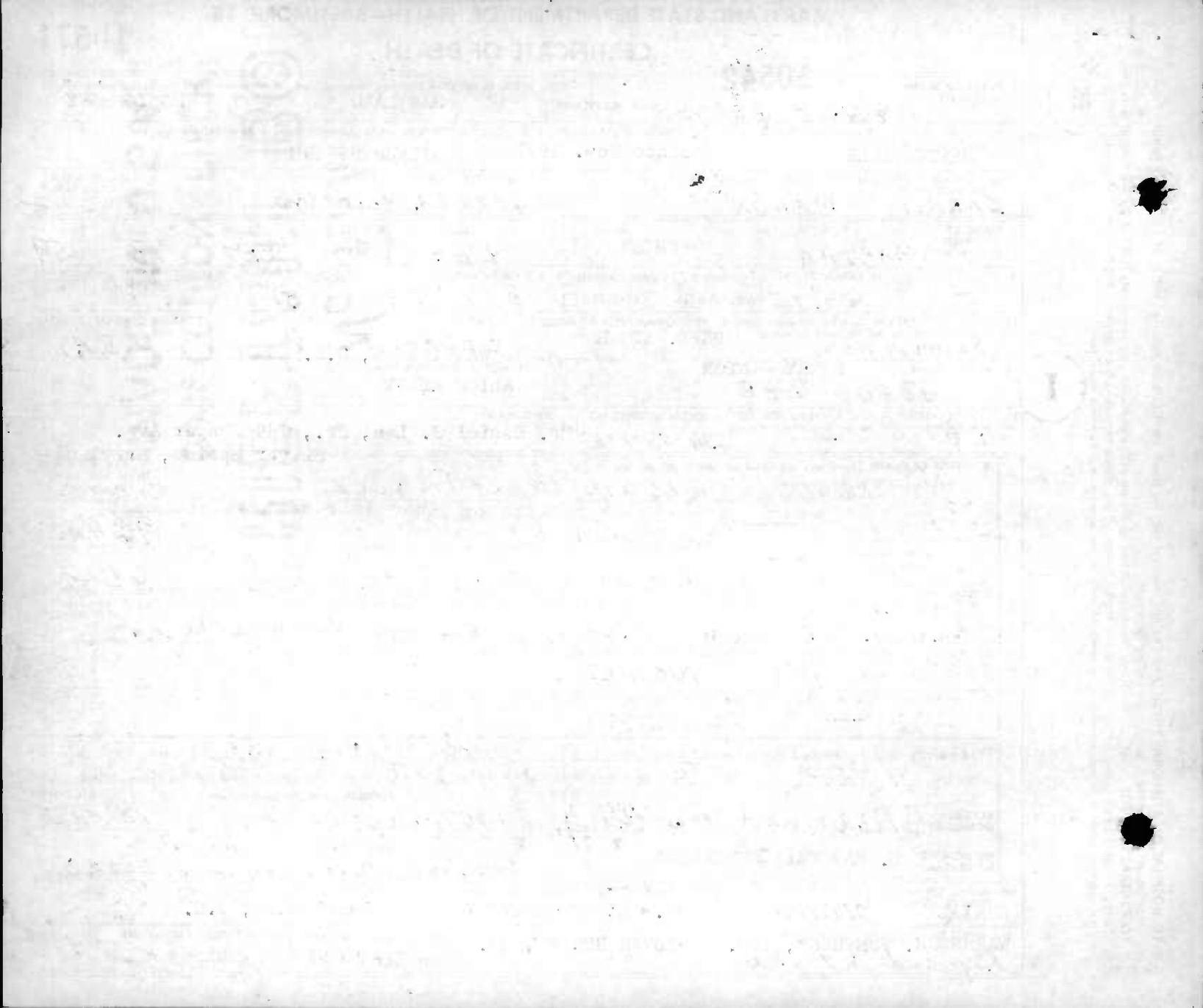
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		10542 PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN lb Since Nov. 1957		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 1556-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR		d. STREET ADDRESS 4922 LASALLE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA		First BENTON	Middle	Last LEE	4. DATE OF DEATH Sept. 18 1959
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/78		9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY BENTON JOHN XXXXX		14. MOTHER'S MAIDEN NAME ALICE RILEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-9763		INFORMANT Mr. Daniel J. Lee, Jr., 749 Thayer Ave. Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Congestive Heart Failure DUE TO Arterial hypertension (had intracranial accident) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SEPTICEMIA DUE TO (c) Post Operative Wound Infection PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH 96 HRS.					
20a. MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1958 to 1959, that I last saw the deceased alive on 11 SEP 1959, and that death occurred at 12:25 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE L. MARSHALL CUVILLIER, M.D. ADDRESS (Street, city or town, state) SILVER SPRING, MD. DATE SIGNED 10 SEP 59					
PHYSICIAN'S NAME (Type) L. MARSHALL CUVILLIER		22o. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 9/21/59 22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY 22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPKHKEY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 23 '59 24b. REGISTRAR'S SIGNATURE Charles & Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10543

CERTIFICATE OF DEATH

10572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Hyattsville Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arlington, Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, MD.		c. LENGTH OF STAY IN 1b Two years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home				d. STREET ADDRESS 2419 North Powohatan		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First M.	Middle Lehning	Lost	4. DATE OF DEATH September	Month 21	Day Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1884	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 23 Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Lauder		14. MOTHER'S MAIDEN NAME Maria O'Meara					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 121-09-0870D		17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		(a) <i>Acute Pulmonary Edema</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1st done</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <i>Hypertensive heart Disease</i>				2 years	
DUE TO		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1</i> , 1958, to <i>Sept 21</i> , 1959, that I last saw the deceased alive on <i>Sept 20</i> , 1959, and that death occurred at <i>9:55 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Bernie Hellin</i> M.D.				ADDRESS (Street, city or town, state) <i>3524 Hyattsville</i>		DATE SIGNED <i>9-55-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-22-59		22c. NAME OF CEMETERY OR CREMATORIUM Calvary Cemetery		22d. LOCATION (City, town, or county) New York, (State) N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Collins</i>		ADDRESS Wash. D. C.		24a. REC'D BY REGISTRAR SEP 24 1959		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Frank</i>	
FRANCIS J. COLLINS 3821-14TH. ST. N. W.				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please report carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

RECEIVED IN THE OFFICE OF THE SECRETARY OF STATE, CHICAGO, ILLINOIS, ON THE 12TH DAY OF NOVEMBER, 1900.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10573

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mass. b. COUNTY Barnstable	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Steve Sture Waldemar Lofgren		First	Middle
		Last	4. DATE OF DEATH Sept. 29
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12 Dec 1891
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dyer		10b. KIND OF BUSINESS OR INDUSTRY Cloth	11. BIRTHPLACE (State or foreign country) Sweden
13. FATHER'S NAME Christian Lofgren		14. MOTHER'S MAIDEN NAME Carolina ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 010 072 124	17. INFORMANT Betty A. Lofgren (Wife) Same as # 2
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure			
DUE TO 442X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor	(County) Maryland
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DATE SIGNED 9/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/1/59	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) Colmar Manor	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR OCT 1 '59		24b. REGISTRAR'S SIGNATURE Carlyle J. Thorne	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10625

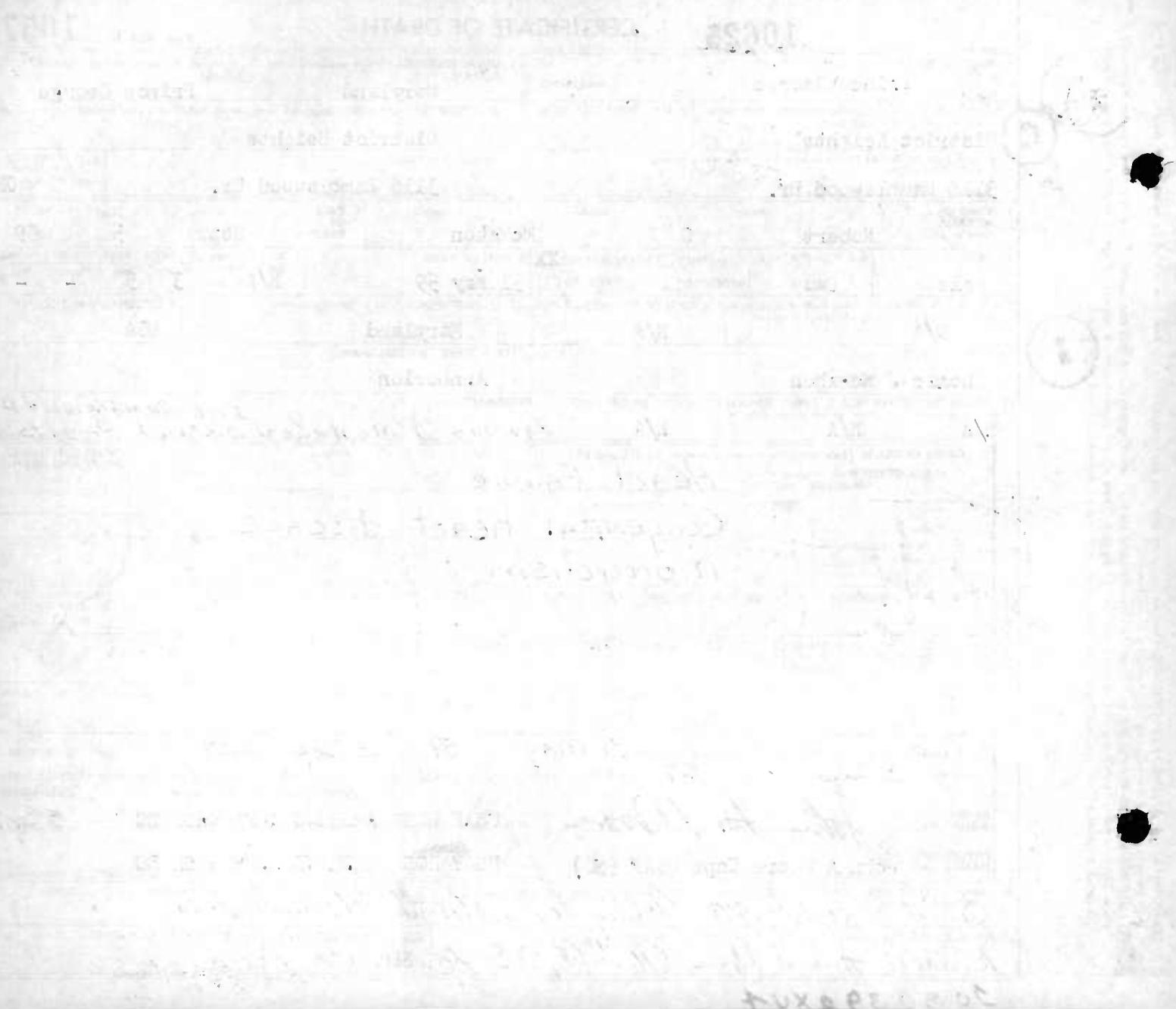
CERTIFICATE OF DEATH

Reg. Dist. No.

10574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X District Heights		d. STREET ADDRESS 3116 Ramblewood Dr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3116 Ramblewood Dr.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert		First G	Middle 	Last McMahon	4. DATE OF DEATH Sept 5 1959	Month Sept	Day 5	Year 1959	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 May 59	9. AGE (In years last birthday) N/A yrs.	IF UNDER 1 YEAR 3 Months	IF UNDER 24 HRS 5 Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas J McMahon				14. MOTHER'S MAIDEN NAME AnnDorion					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A		INFORMANT Thomas J McMahon		Address 3116 Ramblewood Dr District Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO 7545									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease DUE TO (c) Mongolism									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) UNK		(County) 	(State)
21. I certify that I attended the deceased from 31 May , 19 59 , to 3 Sep , 19 59 , that I last saw the deceased alive on 3 Sep , 19 59 , and that death occurred at UNK M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) ADDRESS									DATE SIGNED 5 Sep 59
ACTUAL SIGNATURE <i>John A. Moore</i>		M.D. USAF HOSP ANDREWS AAFB WASH DC							
PHYSICIAN'S NAME (Type) John A. Moore Capt USAF (MC)		USAF HOSP ANDREWS AAFB WASH DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 9, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Arling ton National		22d. LOCATION (City, town, or county) Arling ton Va.		(State) 	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kinalli funeral Home</i>		ADDRESS 816 H St. NE DC		24a. REC'D BY REGISTRAR D SEP 8 '59		24b. REGISTRAR'S SIGNATURE Carroll & sons			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10575

10626

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> D.C. b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Camp Springs</i>		c. LENGTH OF STAY IN 1b <i>23 Hrs 40 Min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Andrews</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>USAF Hospital Andrews</i>		d. STREET ADDRESS <i>3412 19th St., S.E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>NewBorn</i>		First	Middle	Last <i>McPherson</i>	4. DATE OF DEATH Month <i>September</i> Day <i>17</i> Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Mongolian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>September 16 1959</i>	9. AGE (In years last birthday) yrs. <i>23</i>	IF UNDER 1 YEAR Months <i>40</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NA</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NA</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Dempster E McPherson</i>		14. MOTHER'S MAIDEN NAME <i>Miyoko Kashima</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>NA</i>	INFORMANT <i>See Sec 13</i>	Address <i>3412 19th SE Wash 20 D.C.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Premature Birth (c)					
INTERVAL BETWEEN ONSET AND DEATH <i>23 Hrs</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>September 16 1959</i> , to <i>September 17 1959</i> , that I last saw the deceased alive on <i>September 17</i> , 1959, and that death occurred at <i>04.25A</i> M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED <i>Sep 17, 59</i>					
ACTUAL SIGNATURE <i>John A. Moore</i> M.D. USAF Hospital Andrews					
PHYSICIAN'S NAME (Type) JOHN A MOORE Capt USAF MC USAF Hospital Andrews Air Force Base, Wash 25, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>9-17-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>District of Columbia Morgue, Washington, D. C.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ---		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>SEP 22 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

1. FRONTIER - CLASS 30 HAS BEEN STATE OF MONTANA

FRONTIER CLASS 30

10051

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10627

CERTIFICATE OF DEATH

Reg. Dist. No.

10576

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Land Over Hills		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Land Over Hills, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7409 Upshur Street		d. STREET ADDRESS 7409 Upshur Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Brookman	4. DATE OF DEATH Month Sept. Day 13 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1877
9. AGE (In years from birth to death) 81		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 81 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Brookman Wall		14. MOTHER'S MAIDEN NAME Louisa Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Emily Morris	
17. INFORMANT Address 7409 Upshur St. Land Over Hills, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Congestive FAILURE Arterio-Sclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23- , 19 57 , to 9-13- , 19 57 , that I last saw the deceased alive on 9-14- , 19 57 , and that death occurred at 1:30A M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert Roth</i> PHYSICIAN'S NAME (Type) Albert Roth		ADDRESS (Street, city or town, state) M.D. 5510 Madison St. Riverdale, Md. DATE SIGNED 9/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/16/59	
22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knarr</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10577

10544

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Md			c. LENGTH OF STAY IN 1b 7 months		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bell Nursing Home			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Md.		
3. NAME OF DECEASED (Type or print) John Craig Morrison			4. DATE OF DEATH Month Day Year Sept 30, 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 24, 1959		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME James L. Morrison			14. MOTHER'S MAIDEN NAME Barbara P Helmer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Bell Nursing Home	Address West Hyattsville Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 325.4 DUE TO <i>Terminal bronchopneumia</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Upper lip infection DUE TO (c) Myocarditis with congenital heart disease DUE TO <i>birth on</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/30/59 , to 9/30/59 that I last saw the deceased alive on 9/30/59 , 19 59 , and that death occurred at 4:45 M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) College Park, Md.					
DATE SIGNED 10/1/59					
ACTUAL SIGNATURE Thomas A. Christensen M.D.					
PHYSICIAN'S NAME (Type) Thomas A Christensen					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/59		22c. NAME OF CEMETERY OR CREMATORIUM George Washington	
22d. LOCATION (City, town, or county) Hyattsville Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.					
24a. REC'D BY REGISTRAR DATE OCT 5 1959					
24b. REGISTRAR'S SIGNATURE Arthur S. French					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												10578
10582 CERTIFICATE OF DEATH												
												Reg. Dist. No.
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
a. COUNTY Prince Georges						a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						b. COUNTY Montgomery						
c. LENGTH OF STAY IN 1b 4 hrs. 15 min.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1556.2						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital						d. STREET ADDRESS 1022 University Blvd.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First Nora	Middle M.	Last Nasella	4. DATE OF DEATH September 16 1959	Month September	Day 16	Year 1959				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1909	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Anible Nasella						14. MOTHER'S MAIDEN NAME Julia H. Dugan						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		INFORMANT Miss Victoria M. Nasella, 1022 University Blvd.,		Address Silver Spring, Md.		East				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) ADDRESS (Street, city or town, state)		(County)		(State)		
21. I certify that I attended the deceased from Sept 16, 1959, to Sept 16, 1959, that I lost sight of the deceased alive on Sept 16, 1959, and that death occurred at 8 P.M., from the causes and on the date stated above.												
ACTUAL SIGNATURE <i>William D. Rosson M.D.</i>												
DATE SIGNED 5304 Annapolis Road 9/17/59												
PHYSICIAN'S NAME (Type) Dr. William Rosson		ADDRESS SILVER SPRING, MD.										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/21/59		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MARYLAND		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR DATE SEP 21 '59										
<i>Raymond A. Zuka</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. Kraus</i>										

SECOND SIDE

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10628

CERTIFICATE OF DEATH

10579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roger Heights Md.	c. LENGTH OF STAY IN lb 13 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Roger Heights Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5027 54th Place	d. STREET ADDRESS 5027 54th place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John NICHOLAS	First	Middle	Last
			OLIVER
4. DATE OF DEATH September 2, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 22, 1915
9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Pasquale Oliver		14. MOTHER'S MAIDEN NAME Theresa Barone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W 11		16. SOCIAL SECURITY NO. 17. INFORMANT Adella E Oliver Roger Heights Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Concussions of Stomach with Metastasis to lungs & pleurae 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 1959, to <u>Sept 2</u> , 1959, that I last saw the deceased alive on <u>August 28</u> , 1959, and that death occurred at <u>GIA</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5304 Pennsylvania Road Bladensburg, Maryland DATE SIGNED	
ACTUAL SIGNATURE William D. Rosson, M.D.	PHYSICIAN'S NAME (Type) William D. Rosson		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/5/59	22c. NAME OF CEMETERY OR CREMATORIUM St Marys Cemetery	22d. LOCATION (City, town, or county) (State) Hanover Township Pa.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE SEP 4 '59
			24b. REGISTRAR'S SIGNATURE Curtis & Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FD-247 (Rev. 1-25-68)

10

*2/28/85
John G. Miller
and wife*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10580

Reg. Dist. No.

10629

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Brentwood

c. LENGTH OF STAY IN 1b

2 months

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3339 Buchanan Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY

Pr. Geo.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

34 Brentwood

d. STREET ADDRESS

3339 Buchanan Street

e. IS RESIDENCE
ON A FARM?

YES NO

**3. NAME OF
DECEASED
(Type or print)**

First
Walter

Middle
Theodore

Last
Owens

4. DATE
OF
DEATH

Sept.

26

1959

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

3-2-14

9. AGE (in years
last birthday)

45

yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Mail Carrier

10b. KIND OF BUSINESS OR INDUSTRY

Post office

11. BIRTHPLACE (State or foreign country)

Dist of Columbia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Theodore
James ~~X~~ Owens

14. MOTHER'S MAIDEN NAME

Edna Mae Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

Yes U. S. Navy 1943-45

16. SOCIAL SECURITY NO.

577-09-5920

17. INFORMANT

Address
Walter T. Owens, Jr., Hyattsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemorrhage and shock

INTERVAL BETWEEN
ONSET AND DEATH

462.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

Rupture of esophageal varix

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED? YES NO

Pulmonary edema and congestion; Cerebral edema and congestion

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John T. Maloney

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

Sept. 27, 1959

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/30/59

22c. NAME OF CEMETERY OR CREMATORIUM

Arlington National

22d. LOCATION (City, town, or county)

Arlington Va.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons Hyattsville, Maryland.

ADDRESS

24a. REC'D BY REGISTRAR

DATE 30 '59

24b. REGISTRAR'S SIGNATURE

C. L. & T. Inc.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DE EIGENHEIDEN VAN DE STADT DORDRECHT
EN DE GEMEENTE DORDRECHT



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10583

CERTIFICATE OF DEATH

Reg. Dist. No.

10581

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		2	
1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince Georges	
c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Landover Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital		d. STREET ADDRESS 6814 Emerson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alma		First Alma	Last Virginia Parrish
4. DATE OF DEATH Sept. 2 1959		Month Sept.	Day 2
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 13 March 1926		9. AGE (In years lost birthday) 33 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edgar Talbott		14. MOTHER'S MAIDEN NAME Agnes Phelps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	INFORMANT William Parrish
			Address Landover Hills, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Myocardial failure. A cut spine to the coronary art - 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-9- , 19 59 , to 9-2 , 19 59 , that I last saw the deceased alive on 9-1 , 19 59 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 1726 I ST., N.W. Washington 6, D.C. 9/2/59	
ACTUAL SIGNATURE Saul Schwartzbach		DATE SIGNED Washington D. C.	
PHYSICIAN'S NAME (Type) Dr. Saul Schwartzbach			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 95/59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gash's Sons		ADDRESS Hyattsville Md.	24a. REC'D BY REGISTRAR DATE SEP 4 '59
			24b. REGISTRAR'S SIGNATURE Arthur & Frank

1955 TO STADIUM

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10582

10630

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS	c. LENGTH OF STAY IN 1b 4 MONTHS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON	d. STREET ADDRESS 1111 ARMY NAVY DRIVE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM	First W	Middle PASCOE	4. DATE OF DEATH SEPTEMBER 10 1959
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 24, 1906
9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 1 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER COLONEL	10b. KIND OF BUSINESS OR INDUSTRY USAF	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES PASCOE	14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 1935 TO DATE	INFORMANT WILLIAM W PASCOE JR	3620 ^{Address} GUNSTON ROAD ARLINGTON, VIRGINIA
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO METASTATIC CARCINOMA INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CARCINOMA LUNG, LEFT 4 MONTHS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1959 , to 10 SEP 1959 , that I last saw the deceased alive on 9 SEP 1959 , and that death occurred at 9:35A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Philip E. Levy M.D. USAF HOSP ANDREWS, ANDREWS AFB 10 SEP 59			
ACTUAL SIGNATURE PHILLIPS A COX LT COL USAF MC USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF SEPT. 14, 1959	22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) ARLINGTON Va.
23. FUNERAL DIRECTOR'S SIGNATURE Liaudi Funeral Home Inc.	ADDRESS 816 H St. NE, DC	24a. REC'D BY REGISTRAR DATE SEP 14 '59	24b. REGISTRAR'S SIGNATURE Orlina E. Thomas

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10583

10631

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boulevard Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boulevard Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>2704-49 Avenue SE</i>		d. STREET ADDRESS <i>3704-49 Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Petrella</i>	4. DATE OF DEATH Month <i>Sept</i> Month <i>22</i> Day <i>1959</i>
5. SEX <i>Male</i>	COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-8-1902</i>
9. AGE (In years at birthday) <i>56</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>	11. KIND OF BUSINESS OR INDUSTRY <i>None</i>	12. BIRTHPLACE (State or foreign country) <i>Italy</i>
13. FATHER'S NAME <i>Nicolo Petrella</i>	14. MOTHER'S MAIDEN NAME <i>Teresa De Pasco</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>393-09-8060</i>	17. INFORMANT <i>Teresa Petrella</i>	Address <i>Sanctuary</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>myocardial infarction</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of Urinary Bladder</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9-14-59</i> , 19 <i>59</i> , to <i>9-22</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9-16-59</i> , 19 <i>59</i> , and that death occurred at <i>99</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1150 Franklin St. Wash DC</i>			
ACTUAL SIGNATURE <i>Paul B. Bender</i>	DATE SIGNED <i>9-23-59</i>		
PHYSICIAN'S NAME (Type) <i>Paul B. Bender, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL <small>(Specify)</small> <i>Burial</i>	22b. DATE THEREOF <i>9/23/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) <i>Washington</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gobern Mattingly</i>	ADDRESS <i>131-17th St. Wash DC</i>	24e. REC'D BY REGISTRAR DATE <i>SEP 25 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Kuhn</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00 BROWNSBURG—INDIANAPOLIS TO THE STATE CAPITAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10584

Reg. Dist. No.

10584

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Largo		d. STREET ADDRESS 7903 Whitehouse Road			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annette		First	Middle	Lost	4. DATE OF DEATH September 20 1959	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-22-59	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days less 2 days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Pinkney				14. MOTHER'S MAIDEN NAME Dorothea Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Dorothea Pinkney; same address		Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus with meningocele									
752X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 									
DUE TO (c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) 	(State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED September 20, 1959							
EXAMINER'S NAME (Type) John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) 		22b. DATE THEREOF 9-23-59		22c. NAME OF CEMETERY OR CREMATORIAL Hall Family Cm.		22d. LOCATION (City, town, or county) Woodmere Md			
23. FUNERAL DIRECTOR'S SIGNATURE Nancy J Washington		ADDRESS 467 N St N.W.		24a. REC'D BY REGISTRAR SEP 24 '59		24b. REGISTRAR'S SIGNATURE C. Lewis & Krause			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE BOARD OF EXAMINERS OF TEACHERS
TEACHING CERTIFICATE

NAME	ADDRESS	AGE	SEX	EDUCATION	STATE	EXAMINER'S SIGNATURE
John Smith	123 Main Street, Springfield, Missouri	35	M	High School Graduate	Missouri	John Smith
TEACHING CERTIFICATE						
I hereby certify that John Smith is qualified to teach in the public schools of the State of Missouri.						
John Smith						
Date: May 15, 1985						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10585

10585

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlottesville		c. LENGTH OF STAY IN 1b (9Hr)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS Route 2 Box 200A		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Last	4. DATE OF DEATH Proctor	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 / 16 / 59	9. AGE (In years lost birthday) yrs. 6	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 3	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles H Proctor				14. MOTHER'S MAIDEN NAME Mary Proctor				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mary E. Proctor Rt. 2, Upper Marlboro, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		DUE TO Bronchial Pneumonia				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Sept. 18, 1959 to Sept. 19, 1959 , that I last saw the deceased alive Sept. 19, 1959 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>John W. Perkins</i>				ADDRESS (Street, city or town, state) M.D. 5301 Hamilton St., Hyattsville, Md.		DATE SIGNED 9/19/59		
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-59		22c. NAME OF CEMETERY OR CREMATORIUM St. Ignatius Church		22d. LOCATION (City, town, or county) Oxon Hill, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE JOHN T. RHINES & CO By Robert L. Plummer		ADDRESS 3015 12th St N. E. Washington, D. C.		24a. REC'D BY REGISTRAR SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Tracy		

ADOC and S. such

Initials L. T. C. and S. such

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10586

10586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges		Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly		6 hrs		Washington 28 D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Prince Georges General Hospital					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
			L.	Pugh	Month Day Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	16 Mar. 1890	69	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Office worker		U S Government		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Pugh		Laura V Pugh		U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT	Address
				Virginia Royalty	Parkland Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident INTERVAL BETWEEN ONSET AND DEATH					
331X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 7, 1959, to Sept. 7, 1959, that I last saw the deceased alive on Sept. 7, 1959, and that death occurred at 6.20A M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE William D Rosson MD 5304 Annapolis Road 9/77					
PHYSICIAN'S NAME (Type) Dr. William D. Rosson Bladensburg Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 10, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St Georges Cemetery	
22d. LOCATION (City, town, or county) Glenndale, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR SEP 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur & Kraus	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1SM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges MARYLAND		a. STATE Maryland	b. COUNTY Calvert
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly	D.O.A.	Dunkirk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Prince Georges General Hospital		Fisher's Station	
3. NAME OF DECEASED (Type or print)	First Josh	Middle Joseph	CREEK Last Quick
4. DATE OF DEATH	Month September	Day 18	Year 19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	Col.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-29-26
9. AGE (In years last birthday) 32 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 2	12. IF UNDER 24 HRS. Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Board of Education	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME John Quick		14. MOTHER'S MAIDEN NAME Rosie Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-1246	
17. INFORMANT		Address Mary G. Green; Upper Marlboro. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock			
982 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Stab wound of chest			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed with a knife held in the hands of another person.			
20c. TIME OF INJURY Hour 8.30 p.m.	Month, Day, Year 9-18 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pool Room
20f. (City or town) Upper Marlboro	(County) Pr. Geo.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Sept 19, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 23, 1959	22c. NAME OF CEMETERY OR CREMATORIAL ROZION	22d. LOCATION (City, town, or county) Lot 614
23. FUNERAL DIRECTOR'S SIGNATURE <i>Buried Huddayy Hallsville Ltd</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 29 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur W. Evans</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

*O T₁ T₂ T₃ T₄ T₅ T₆ T₇ T₈ T₉ T₁₀ T₁₁ T₁₂ T₁₃ T₁₄ T₁₅ T₁₆ T₁₇ T₁₈ T₁₉ T₂₀ T₂₁ T₂₂ T₂₃ T₂₄ T₂₅ T₂₆ T₂₇ T₂₈ T₂₉ T₃₀ T₃₁ T₃₂ T₃₃ T₃₄ T₃₅ T₃₆ T₃₇ T₃₈ T₃₉ T₄₀ T₄₁ T₄₂ T₄₃ T₄₄ T₄₅ T₄₆ T₄₇ T₄₈ T₄₉ T₅₀ T₅₁ T₅₂ T₅₃ T₅₄ T₅₅ T₅₆ T₅₇ T₅₈ T₅₉ T₆₀ T₆₁ T₆₂ T₆₃ T₆₄ T₆₅ T₆₆ T₆₇ T₆₈ T₆₉ T₇₀ T₇₁ T₇₂ T₇₃ T₇₄ T₇₅ T₇₆ T₇₇ T₇₈ T₇₉ T₈₀ T₈₁ T₈₂ T₈₃ T₈₄ T₈₅ T₈₆ T₈₇ T₈₈ T₈₉ T₉₀ T₉₁ T₉₂ T₉₃ T₉₄ T₉₅ T₉₆ T₉₇ T₉₈ T₉₉ T₁₀₀

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10632

CERTIFICATE OF DEATH

10588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Coastal 1556.2</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burke Felicity</i>		c. LENGTH OF STAY IN 1b <i>4 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>8206 New Hampshire Silver Spring MD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fair Branch Nursing Home</i>		e. STREET ADDRESS <i>8206 New Hampshire Ave</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Bertha Katherine Lisenberry</i>		First	Middle	Lost	4. DATE OF DEATH Month <i>Sept.</i> Day <i>7</i> Year <i>1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27, 1882</i>		9. AGE (In years lost birthday) yrs. <i>77</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Ezra St. howman</i>		14. MOTHER'S MAIDEN NAME <i>Lydia M. Messick</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Nursing Home Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		DUE TO <i>Pulmonary Edema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>Left ventricular failure</i>			
(c)		<i>Cerebral Vascular Hemorrhage</i>		4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-1</i> , 19 <i>59</i> , to <i>9-7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9-6</i> , 19 <i>59</i> , and that death occurred at <i>10:15 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. H. Sandstrom</i>		M.D. <i>26 Lee Ave, Takoma Park, Md</i>		ADDRESS (Street, city or town, state) <i>9-7-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur. Trans.</i>		22b. DATE THEREOF <i>9-7-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or county) (State) <i>Roanoke County, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>SEP 11 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	

MATERIALS STATE DEPARTMENT OF NATURE CALIFORNIA

CERTIFICATE OF DESIGN

1962-242

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10588

CERTIFICATE OF DEATH

10589

Reg. Dist. No.

1		M		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		I		10588	
1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Mo. 28 Days		b. COUNTY Prince George	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brandywine	
3. NAME OF DECEASED (Type or print) Julia LaRogue Randall		First	Middle	Last	4. DATE OF DEATH Sept. 25
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH UNK	Month 19 59
8. WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY self	11. BIRTHPLACE (State or foreign country) MINNESOTA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Joseph LaRogue		14. MOTHER'S MAIDEN NAME Elizabeth Zeng		INFORMANT Thomas Phillip LaRogue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 730.2 (b) Multiple abscesses (c) Osteomyelitis of right foot				INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus				2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 27 , 1959, to Sept. 25 , 1959, that I last saw the deceased alive on Sept. 25 , 1959, and that death occurred at 10:50 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 30 Ridge Rd, Greenbelt, Maryland		DATE SIGNED	
ACTUAL SIGNATURE Hans Wodak		M.D.			
PHYSICIAN'S NAME (Type) Dr. Hans Wodak					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-59	22c. NAME OF CEMETERY OR CREMATORIAL ST Paul's Piney	22d. LOCATION (City, town, or county) Waldorf (Md)	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home Waldorf Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 2 '59	24b. REGISTRAR'S SIGNATURE Catherine E. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10590

CERTIFICATE OF DEATH

Reg. Dist. No.

10589

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 25 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 4613 Garret Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Goldman	Middle L.	Last Ray	4. DATE OF DEATH Sept. 19 1959	Month Sept.	Day 19	Year 1959
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 27, 1905	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Agriculture Dept U S Gov't		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Ray			14. MOTHER'S MAIDEN NAME Dora Jackson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT Lillian Ray		Address Beltsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema (c) Coronary thrombosis Atherosclerosis							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 , to 1959 , that I last saw the deceased alive on 9-19 1959 , and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 473 Avenue D, College St., 99 9/19/59							
DATE SIGNED							
ACTUAL SIGNATURE LL. Etienne M.D.							
PHYSICIAN'S NAME (Type) LL. Etienne							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/21/59	22c. NAME OF CEMETERY OR CREMATORIAL George Washington Cemetery		22d. LOCATION (City, town, or county) Hyattsville Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE SEP 22 '59		24b. REGISTRAR'S SIGNATURE Arthur & Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
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100-CONTINUATION OF THE INDEX

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10591

10633

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Prince Georges</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burke</i> <i>Alexandria</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>14 College Park</i>		d. STREET ADDRESS <i>8709 - 48th Ave.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Saint Brigid Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Edward White</i>		First	Middle	Last	4. DATE OF DEATH Month <i>Sept.</i>	Day <i>3</i>	Year <i>1959</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 29, 1893</i>	9. AGE (In years lost/birthday) <i>85 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>H.S. Government - New Jersey</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Edward White</i>		14. MOTHER'S MAIDEN NAME <i>Mary Baker</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unk</i>		17. INFORMANT <i>Records of Nursing</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute coronary insufficiency</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Mitral insufficiency + arteriosclerosis</i> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fx nasal bone. Rheumatoid arthritis</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Haddonfield</i>		(County) <i>N.J.</i>	(State) <i>N.J.</i>
21. I certify that I attended the deceased from <i>8-19</i> , 19 <i>59</i> , to <i>9-3</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8-22</i> , 19 <i>59</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>R. H. Sandstrom</i>		M.D.		ADDRESS (Street, city or town, state) <i>9-3-59</i>		DATE SIGNED		
PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/5/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Locuswood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Haddonfield</i>			
23a. DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Thorne</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10634

CERTIFICATE OF DEATH

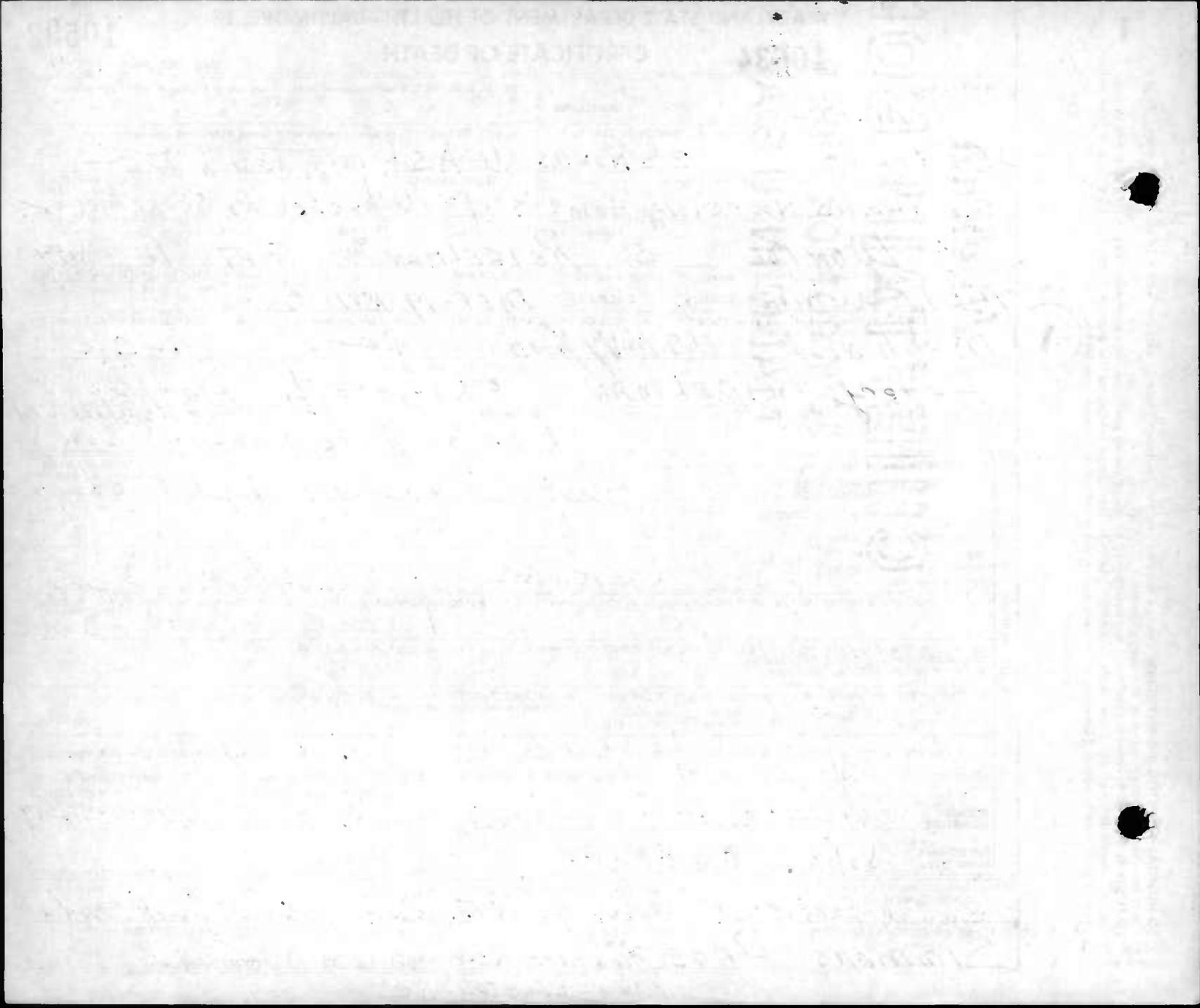
Reg. Dist. No.

10592

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>PRINCE Geo.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SUITLAND</i>		c. LENGTH OF STAY IN 1b <i>3 1/2 MONTHS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUITLAND NURSING HOME</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MONROE</i>		First <i>S.</i>	Middle <i>Reigelman</i>
Last <i>REIGELMAN</i>		4. DATE OF DEATH <i>SEPT 16 1959</i>	Month Day Year
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>MAR-19-1881</i>		9. AGE (In years lost birthday) <i>78 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. NAVY Yard</i>	11. BIRTHPLACE (State or foreign country) <i>Pa.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Henry Reigelman</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Heckel</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>BURTON R. Reigelman</i>		17. INFORMANT <i>(son)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1810</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>Gastrovascular Colitis</i>			
(c) DUE TO <i>Carcinoma of Bladder</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>M.D. 2904 Nichols St., Washington D.C.</i>	
ACTUAL SIGNATURE <i>John J. Raedy</i>		DATE SIGNED <i>9-16-59</i>	
PHYSICIAN'S NAME (Type) <i>John J. Raedy</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Sept 19-59</i>		22b. DATE THEREOF <i>1959</i>	
22c. NAME OF CEMETERY OR GREMATORIUM <i>Cedar Hill Cemetery Suitland Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>SIMMONS BROS. 9000 HOPE ROSE</i>		24a. REC'D. BY REGISTRAR <i>1661</i>	24b. REGISTRAR'S SIGNATURE <i>Office of the Coroner</i>
		DATE <i>SEP 18 '59</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10593

Reg. Dist. No.

10635

1. PLACE OF DEATH
a. COUNTY

Prince Georges'

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Prince Georges'

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Brandywine

c. LENGTH OF STAY IN lb

Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Brandywine

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Rt 3., Box 261-B

d. STREET ADDRESS

Rt. 3., Box 261-B

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
William

Middle
Thomas

Last
Richards

4. DATE
OF
DEATH

Month
September
Day
3, 1959
Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

April 17, 1889

9. AGE (In years
last birthday)
70 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Tobacco Farming

10b. KIND OF BUSINESS OR INDUSTRY

Own Farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Richards

14. MOTHER'S MAIDEN NAME

Margaret Goldsmith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-34-4796

INFORMANT

Address

Ida R. Richards -Same as above.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Due to

myocardial infarction

INTERVAL BETWEEN
ONSET AND DEATH

8 Days

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

Renal Colic - Visual Renal Alleviation

year

Due to

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. ————— 19 p. m. —————

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) ————— (State) —————

21. I certify that I attended the deceased from July 1, 1955, to Sept 3, 1957, that I last saw the deceased alive on Sept 3rd, 1959, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Ritchie Bros.

M.D.

Baltimore, Md.

Sep 5-57

PHYSICIAN'S
NAME (Type)

K. Dobson

Baltimore, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/7/59

22c. NAME OF CEMETERY OR CREMATORIUM

Immanuel Cemetery

22d. LOCATION (City, town, or county)

Horsehead

(State)
Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Ritchie Bros. Funeral Home - Upper Marlboro, Md.

ADDRESS

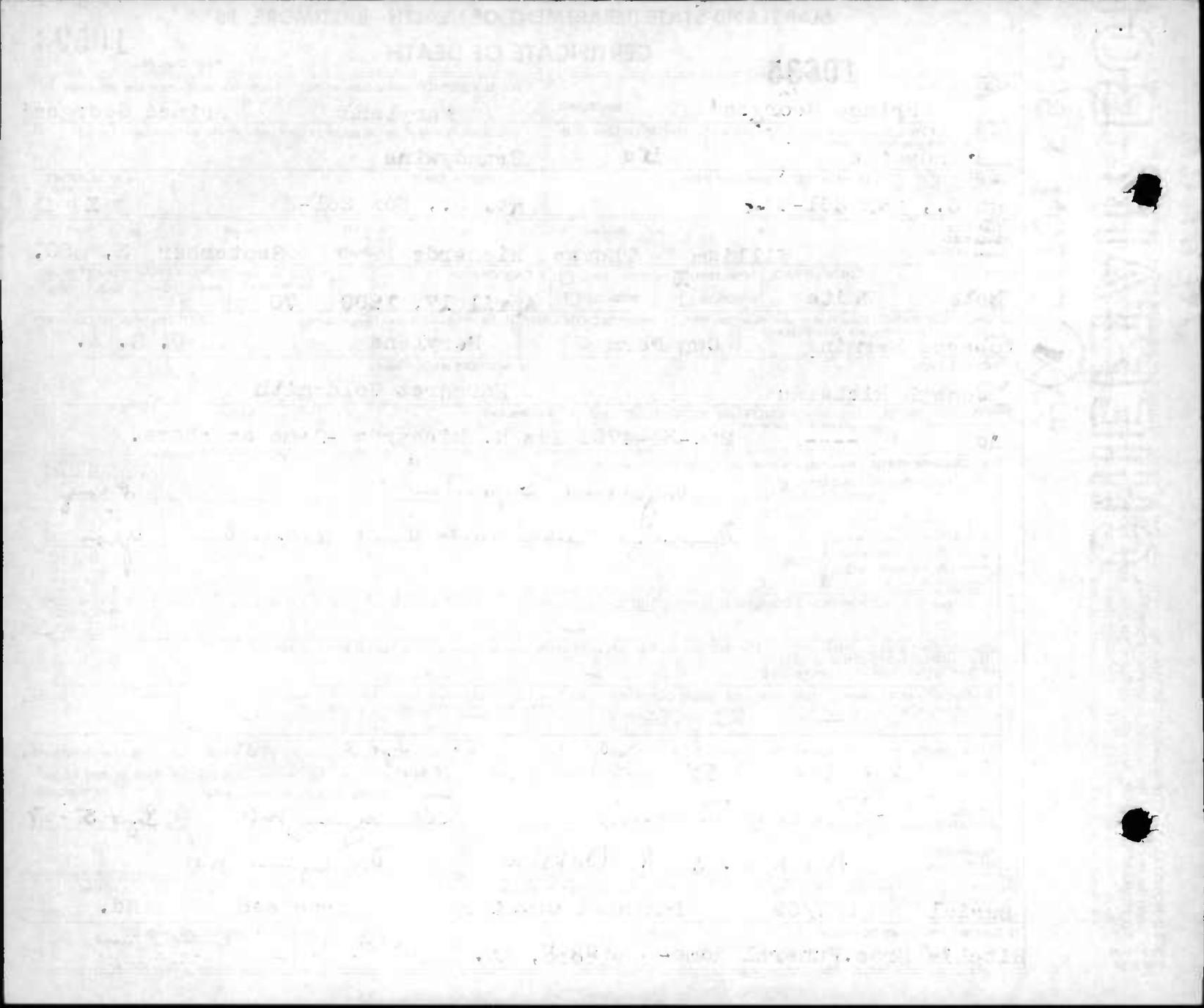
24a. REC'D BY REGISTRAR

SEP 14 1959

24b. REGISTRAR'S SIGNATURE

Richard K. Dobson

DATE



10594

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files!

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN lb transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parking lot at 2201 Varnum St. Mt. Rainier		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier	
3. NAME OF DECEASED (Type or print) Isaac Arthur Sayre		d. STREET ADDRESS 3504 Shepherd Street	
4. DATE OF DEATH September 23		Month	Day
		Year	Year
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-11-00		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Liquor	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Saban Sayre		14. MOTHER'S MAIDEN NAME Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-07-8520	
17. INFORMANT Margaret M. Bigley; 3417 Tilden St. Brentwood		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure			
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED September 23, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur & Kline</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince Georges MARYLAND		a. STATE Maryland	b. COUNTY Pr. Geo.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly	D.O.A.	X Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Prince Georges General Hospital		1104 58th Avenue, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Iela	Middle O'Rear	Last Schenck
4. DATE OF DEATH	Month Sept.	Day 12,	Year 19 59
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1917
10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James O'Rear		14. MOTHER'S MAIDEN NAME Jessie Daniel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address William G. Schenck; 630 E. Capitol St., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gun shot wound of head DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head	
20c. TIME OF INJURY Month, Day, Year Hour 8:00 p.m. 9-12-1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Hillside		(County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 16-59	
22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Bladensburg, Maryland. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dimmick Bros</i>		ADDRESS 1661- Good Hope Road S.E. Washington, D.C.	24a. REC'D BY REGISTRAR DATE SEP 14 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PHYSICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10596

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS Rt. #1 Box 302, Highridge Rd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lewis		First	Middle	Lost	4. DATE OF DEATH Scroggins	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 27, 1906	9. AGE (In years lost birthday) 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Highway Maintenance Man.		10b. KIND OF BUSINESS OR INDUSTRY State Roads Commission		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Scroggins		14. MOTHER'S MAIDEN NAME Hattie Mulligan						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 157X		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic Carcinoma pancreas 2 weeks DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 9/9/57						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9/9/57 , to 9/18/57 , that I last saw the deceased alive on 9/19/57 , and that death occurred at 157 Washington Blvd., Laurel, Md. ADDRESS (Street, city or town, state) 157 Washington Blvd., Laurel, Md. DATE SIGNED 10/1/57								
ACTUAL SIGNATURE Oscar B. Camp		PHYSICIAN'S NAME (Type) OSCAR B. CAMP						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/57		22c. NAME OF CEMETERY OR CREMATORIUM Any Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Danaldson Laurel Md		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 23 '59		24b. REGISTRAR'S SIGNATURE C. L. Hause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10597

10592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,		c. LENGTH OF STAY IN 1b 7½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Vista		d. STREET ADDRESS Box 212			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charity		First	Middle	Last	4. DATE OF DEATH Seltzer	Month September	Day 16	Year 1959	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1894		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Weeks				14. MOTHER'S MAIDEN NAME Mary Kimbel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Samuel Seltzer, Husband		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO Cerebral Vascular Accident.				INTERVAL BETWEEN ONSET AND DEATH Acute... 8 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Sept 16, 1959, to Sept 16, 1959, that I last saw the deceased alive on Sept 16, 1959, and that death occurred at 11:40 PM, from the causes and on the date stated above.									
ACTUAL SIGNATURE Gordon W Kelley						ADDRESS (Street, city or town, state) Lincoln Mem.		DATE SIGNED 11/18/59	
PHYSICIAN'S NAME (Type) Gordon W Kelley									
22a. BURIAL CREMATION, REMOVAL (Specify) 9-21-59		22b. DATE THEREOF 9-21-59		22c. NAME OF CEMETERY OR CREMATORIAL Lincoln Mem.		22d. LOCATION (City, town, or county) Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frager's Funeral Home		ADDRESS 389 R.D. Ave. N.W.		24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE Catherine E. Kimes			

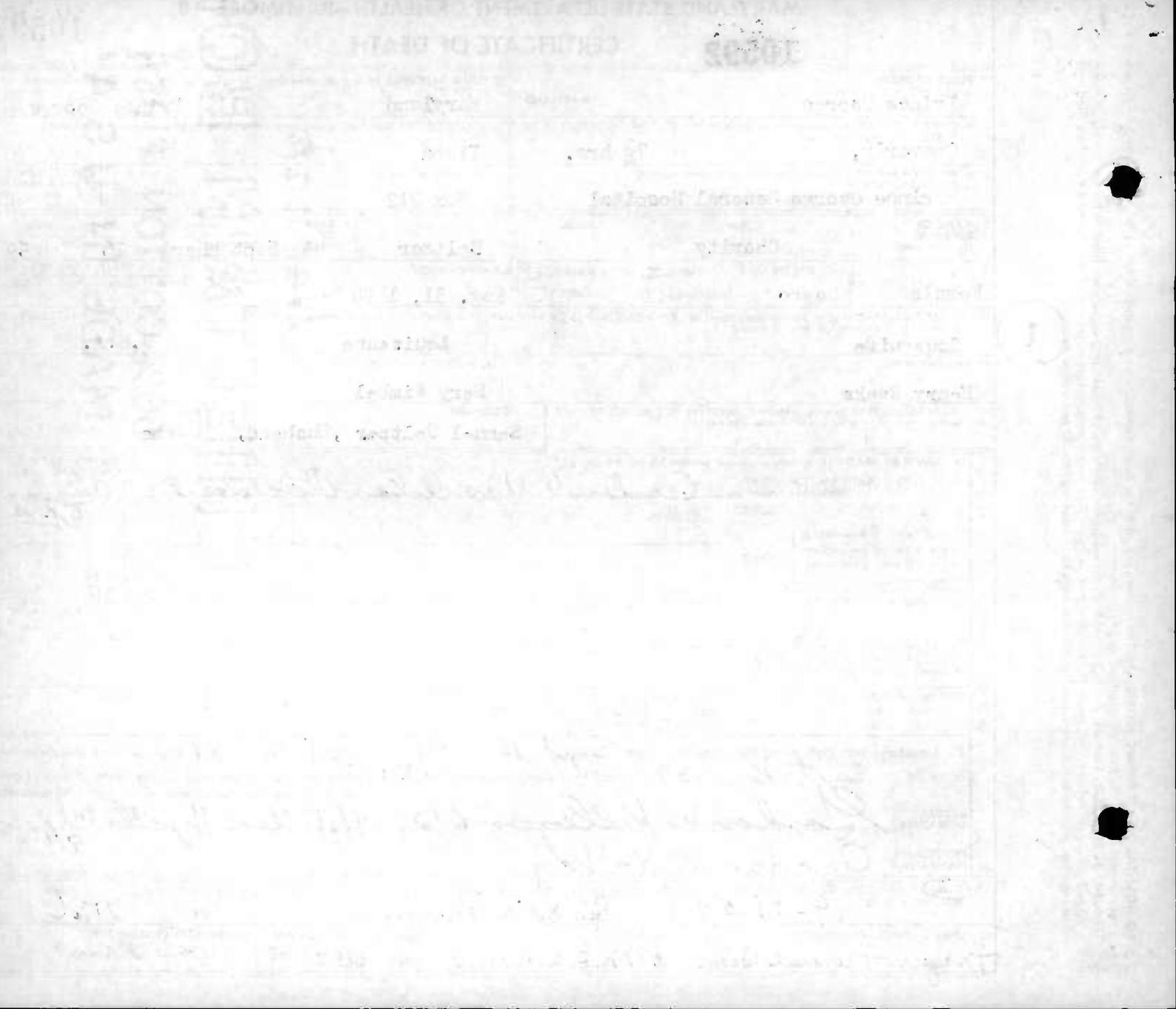
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

BUCKEYED SPARROW

HABITAT



10598

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b D.O.A.					b. COUNTY Pr. Geo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Groome					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Peirce	Middle Duckett	Last Sharp	4. DATE OF DEATH Sept. 13,		Month Sept.	Day 13	Year 1959		
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1-17-35	9. AGE (In years less birthday) 24 yrs.		IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier			10b. KIND OF BUSINESS OR INDUSTRY U.S. Army			11. BIRTHPLACE (State or foreign country) Georgia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lewis Leyton Sharp					14. MOTHER'S MAIDEN NAME Lucille Arwood						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 381-32-4541			17. INFORMANT Identification cards			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma; multiple and severe DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with a tree.								
20c. TIME OF INJURY Hour o. m. 2.20 A.M.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Upper Marlboro		(County) (State) Pr. Geo. Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
John T. Maloney, M.D.										DATE SIGNED Sept. 13, 1959	
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-59		22c. NAME OF CEMETERY OR CREMATORIAL Rimaidi Funeral Home 816 H St., N. E.		22d. LOCATION (City, town, or county) Atlanta, Georgia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rimaidi Funeral Home</i>		ADDRESS 816 H St., N. E.		24a. REC'D BY REGISTRAR SEP 17 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Keane</i>					

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10599

Reg. Dist. No.

10594

1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Pr. Geo.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X (Glen Arden) Ardmore

d. STREET ADDRESS

1st and Jefferson

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First Ernest Frederick Shirley

Middle

Last

4. DATE
OF
DEATH

Sept. 27,

Day

Year
1959

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

June 20, 1923

9. AGE (In years
last birthday)
36 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Pasterer

10b. KIND OF BUSINESS OR INDUSTRY

Dry Wall

11. BIRTHPLACE (State or foreign country)

S. Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas L. Shirley

14. MOTHER'S MAIDEN NAME

Ephew Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

Yes Army

(If yes, give war or dates of service)

Jan. 46 to Dec. 46

16. SOCIAL SECURITY NO.

17. INFORMANT

Geraldine Shirley; same address as #2.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Acute congestive heart failure

INTERVAL BETWEEN
ONSET AND DEATH

422.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

Cardiovascular disease

DUE TO

(c)

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

o. m.

p. m.

White

Not white

at work

at work

20d. INJURY OCCURRED

White

Not white

at work

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

September 27, 1959

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/1/1959

22c. NAME OF CEMETERY OR CREMATORIUM

Fort Lincoln Cemetery

22d. LOCATION (City, town, or county)

Colmar Manor

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

W.W. Chambers Company, Riverdale, Md.

ADDRESS

24a. REC'D BY REGISTRAR

OCT 1 '59

24b. REGISTRAR'S SIGNATURE

Arthur J. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

V.S. A15ME(S)
5M 9/55

Yes **Virya** Jan. 1970. Up to Dec. 1970 Geriatric Unit same address as #5.

Acute congestive heart failure

Cardiotoxins cause disease

Yes Atta sat. file to Dec. file

xx **eʃɪʃw** **əlasm**

Prince Georges General Hospital

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10549

CERTIFICATE OF DEATH

Reg. Dist. No.

10600

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
PRINCE GEORGES MARYLAND		a. STATE	Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY		
MT. RAINIER	38 yrs	PRINCE GEO		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
4219-32 nd Street	16 MT RAINIER			
4. DATE OF DEATH	Month	Day	Year	
SEPT		14	19 59	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	
M	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG 11 1897	
9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
62 yrs.	Months Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
CONST. ENGINEER			WASH. DC.	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
WILLIAM SKINNER		SUSAN C HERRY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		219-01-5841	WIFE Helen G. SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PULMONARY EDEMA		
162.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		6 mos		
(b)		METASTATIC CARCINOMA		
DUE TO		6 mos		
(c)		BRONCHogenic CARCINOMA		
DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT 13, 1959, to SEPT 14, 1959, that I last saw the deceased alive on SEPT 14, 1959, and that death occurred at 11:45 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE		BENJAMIN S. MILLER M.D. 3824-34 St Mt Rainier Sept 14 59		
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial		9/17/59	Fort Lincoln	Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Nalley's Funeral Home, Md.		Mt Rainier	DATE SEP 21 '59	Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2023 RELEASE UNDER E.O. 14176 ITM 73978 MIA STATE GRAYHAWK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10601

10636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale(rural)		Length of stay 5 months & 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 424 New York Ave. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Arthur	Middle	Last	4. DATE OF DEATH Smith Jr.	Month 9	Day 16	Year 19 59
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/25/13	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Smith Sr.		14. MOTHER'S MAIDEN NAME Eveline Woods					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-07-5740		INFORMANT decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic Cor Pulmonale DUE TO (c) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH 14 days unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from olive on 9/16 , 1959, and that death occurred at 11:25A , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>Moe Weiss</i>		DATE SIGNED 9/16/59					
PHYSICIAN'S NAME (Type)		M.D. Glenn Dale Hospital					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/24/59		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malvian and Schey Inc.</i>		ADDRESS <i>424 New York Ave. N.W.</i>		24a. REC'D BY REGISTRAR DATE SEP 23 '59		24b. REGISTRAR'S SIGNATURE <i>Charles J. Knapp</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

RECORDED IN BUREAU

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10637

Reg. Dist. No.

10603

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Prince Georges MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 23 yrs	
Lintham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address)		d. STREET ADDRESS	
Annapolis Road		Bunzel - Vista Annapolis Rd	
3. NAME OF DECEASED (Type or print)		First	Middle
Martha Lewis Smith		Lost	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
Female Negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4-23-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Beautician		Beautyician	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Va.		G.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Albert Henderson		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		William Poinexter Address	
		Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive Heart Failure 2 weeks	
450.0			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Fractured Hip (Femur) 1 mo	
DUE TO		(c) Generalized Atherosclerosis 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Fractured Clavus			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED Sept 3 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/9/59	
22c. NAME OF CEMETERY OR CREMATORIAL Service		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H.N. Harton Co		ADDRESS 1322 U St NW	
		24a. REC'D BY REGISTRAR SEP 8 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Turner	

BY 2006/08/17 FLASH TO THE STATE OF ILLINOIS

RTABO TO STANDARD & POOR'S ILLINOIS

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STATE OF
ILLINOIS

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DEPT. OF STATE

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RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10602

Reg. Dist. No.

10595

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
Prince Georges MARYLAND		Cincinnati, Ohio					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b					
Cheverly		D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Prince Georges General Hospital		d. STREET ADDRESS Billboard Publishing Co 2160 Patterson St.					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
Ray		Smith		Sept, 27,		19 59	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		? 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ride operator		Carnival		Mo.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Unk.		Unk.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Unk.		Unk.		266-18-9402			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u>							
DUE TO <u>Fractured skull</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured skull</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>A pedestrian, struck by an automobile on public highway.</u>							
20c. TIME OF INJURY Hour		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
11.30 p.m.		9-27-59 19		Highway		Hillcrest Hts. Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
John T. Maloney							
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 28, 1959			
John T. Maloney, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Burial		10/2/1959		Evergreen Cemetery		Bla densburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons		Hyattsville		OCT 2 1959		Arthur J. [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF SOUTH DAKOTA
DEPARTMENT OF HEALTH - STATE OF SOUTH DAKOTA

NAME	ADDRESS	PHONE NUMBER	TYPE	EXPIRATION DATE	ISSUED BY	RECEIVED BY	RECEIVED DATE
John Doe	123 Main Street	(555) 123-4567	Class A	06/2024	State Health Dept.	Local Health Dept.	05/2024
Jane Doe	456 Elm Street	(555) 987-6543	Class B	09/2024	Local Health Dept.	State Health Dept.	06/2024
Bob Smith	789 Pine Street	(555) 543-2109	Class C	12/2024	Local Health Dept.	State Health Dept.	07/2024
Sarah Johnson	210 Cedar Street	(555) 321-0987	Class D	03/2025	State Health Dept.	Local Health Dept.	08/2024
David Williams	567 Oak Street	(555) 765-4321	Class E	07/2025	Local Health Dept.	State Health Dept.	11/2024
Mary Brown	890 Maple Street	(555) 234-1234	Class F	10/2025	State Health Dept.	Local Health Dept.	12/2024
Tommy Lee	111 Birch Street	(555) 654-3210	Class G	01/2026	Local Health Dept.	State Health Dept.	04/2024
Emily Davis	333 Spruce Street	(555) 876-5432	Class H	04/2026	State Health Dept.	Local Health Dept.	07/2024
Michael Green	555 Chestnut Street	(555) 432-1234	Class I	07/2026	Local Health Dept.	State Health Dept.	10/2024
Nancy White	777 Willow Street	(555) 987-6543	Class J	10/2026	State Health Dept.	Local Health Dept.	13/2024
Robert Black	999 Pine Street	(555) 543-2109	Class K	01/2027	Local Health Dept.	State Health Dept.	12/2024
Samantha Lee	222 Cedar Street	(555) 321-0987	Class L	04/2027	State Health Dept.	Local Health Dept.	15/2024
Christopher Green	444 Oak Street	(555) 765-4321	Class M	07/2027	Local Health Dept.	State Health Dept.	18/2024
Elizabeth White	666 Birch Street	(555) 234-1234	Class N	10/2027	State Health Dept.	Local Health Dept.	21/2024
Matthew Black	888 Spruce Street	(555) 876-5432	Class O	01/2028	Local Health Dept.	State Health Dept.	24/2024
Karen Lee	111 Chestnut Street	(555) 432-1234	Class P	04/2028	State Health Dept.	Local Health Dept.	27/2024
James Green	333 Willow Street	(555) 987-6543	Class Q	07/2028	Local Health Dept.	State Health Dept.	30/2024
Sarah Black	555 Pine Street	(555) 543-2109	Class R	10/2028	State Health Dept.	Local Health Dept.	33/2024
David Lee	777 Oak Street	(555) 321-0987	Class S	01/2029	Local Health Dept.	State Health Dept.	36/2024
Elizabeth Green	999 Birch Street	(555) 765-4321	Class T	04/2029	State Health Dept.	Local Health Dept.	39/2024
Matthew Black	222 Spruce Street	(555) 234-1234	Class U	07/2029	Local Health Dept.	State Health Dept.	42/2024
Karen Lee	444 Willow Street	(555) 876-5432	Class V	10/2029	State Health Dept.	Local Health Dept.	45/2024
James Green	666 Pine Street	(555) 543-2109	Class W	01/2030	Local Health Dept.	State Health Dept.	48/2024
Sarah Black	888 Oak Street	(555) 321-0987	Class X	04/2030	State Health Dept.	Local Health Dept.	51/2024
David Lee	111 Birch Street	(555) 765-4321	Class Y	07/2030	Local Health Dept.	State Health Dept.	54/2024
Elizabeth Green	333 Willow Street	(555) 234-1234	Class Z	10/2030	State Health Dept.	Local Health Dept.	57/2024

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10596

CERTIFICATE OF DEATH

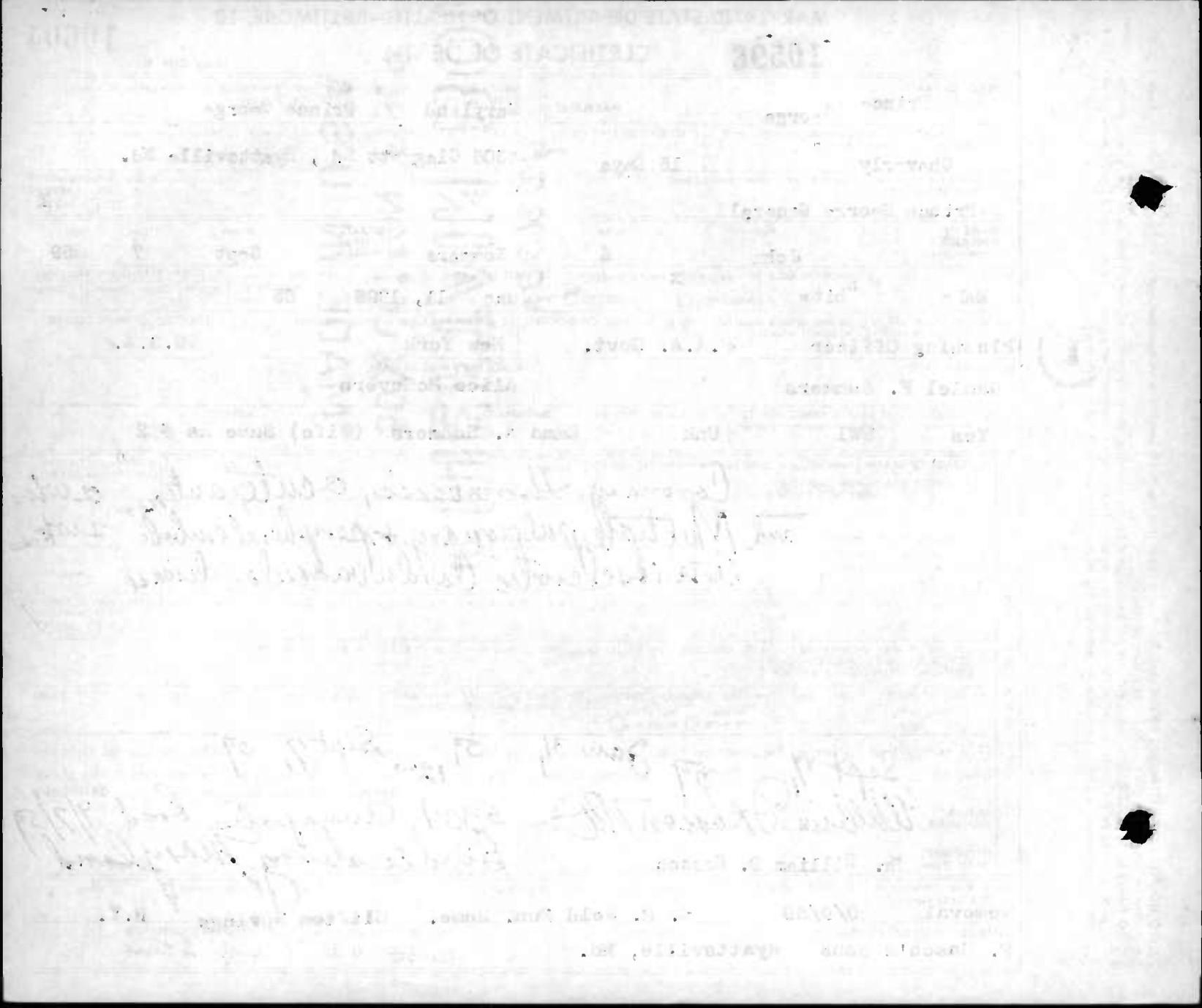
Reg. Dist. No.

10604

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland		b. COUNTY Prince George	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 154306 Claggett Rd, Hyattsville Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) John		First E Middle		Last Sommers		4. DATE OF DEATH Sept 7 1959		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1896		9. AGE (In years last birthday) 63 yrs.	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Planning Officer		10b. KIND OF BUSINESS OR INDUSTRY F.A.A. Govt.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel F. Sommers				14. MOTHER'S MAIDEN NAME Alice McGovern					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. Unk		INFORMANT Emma A. Sommers (Wife)		Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis, acute, anterior 2 wks									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. and Multiple pulmonary & peripheral emboli 2 wks									
DUE TO Antisclerotic Cardiovascular disease -									
DUE TO 									
(c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 31, 1959</u> , to <u>Sept 7, 1959</u> that I last saw the deceased alive on <u>Sept 7, 1959</u> , and that death occurred at <u>1205</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>William D. Rosson M.D.</u>		ADDRESS (Street, city or town, state) <u>5304 Annapolis Road Bladensburg, Maryland</u> DATE SIGNED <u>9/7/59</u>							
PHYSICIAN'S NAME (Type) Dr. William D. Rosson									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/9/59		22c. NAME OF CEMETERY OR CREMATOR Y E. M. Weld Fun. Home.		22d. LOCATION (City, town, or county) Clifton Springs (State) N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 10 '59		24b. REGISTRAR'S SIGNATURE <u>Curtis & Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10638

CERTIFICATE OF DEATH

Reg. Dist. No.

10695

1. PLACE OF DEATH o. COUNTY PRINCE GEO'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY PRINCE GEO'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVONDALE	c. LENGTH OF STAY IN 1b 18 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVONDALE	d. STREET ADDRESS 2025 WOODREEVE ROAD
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2025 WOODREEVE ROAD	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HARRY ELLSWORTH STEFFEY	First	Middle	Last
4. DATE OF DEATH 9 - 19 - 1959	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1896
9. AGE (In years less birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 3	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER RET	10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HARRY E STEFFEY	14. MOTHER'S MAIDEN NAME IDA-R.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. (If yes, give war or date of service)	17. INFORMANT CAIN	Address 2025 WOODREEVE RD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		GENERALIZED ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 9 1/2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT. 27 1951 , to SEPT. 19, 1959 , that I last saw the deceased alive on SEPT. 19, 1959 , and that death occurred at 6:40 PM , from the causes and on the date stated above. ACTUAL SIGNATURE J. E. Bowman PHYSICIAN'S NAME (Type) J. E. BOWMAN, M.D. ADDRESS (Street, city or town, state) 4021-18th St., N.E. DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-22-59	22c. NAME OF CEMETERY OR CREMATORIUM FT LINCOLN CEM.	22d. LOCATION (City, town, or county) (State) BLADENSBURG MD
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Sons	ADDRESS 5801 Cleveland Ave Riversdale Md.	24a. REC'D BY REGISTRAR DATE SEP 22 '59	24b. REGISTRAR'S SIGNATURE John E. K.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												10696			
CERTIFICATE OF DEATH												Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Prince Georges				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				d. STREET ADDRESS 6113 Kenilworth Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Louise	Middle	Last Stephenson		4. DATE OF DEATH Sept. 6 19 59		Month		Day		Year			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6 Oct. 1914		9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME Homer Armstrong				14. MOTHER'S MAIDEN NAME Virginia Mc Cormic											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		INFORMANT Raymond Stephenson		Address Riverdale Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH 78 hr			
DUE TO Cerebral infarct DUE TO Hypotension DUE TO Acute Pancreatitis												3 days 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-31 , 19 59 , to 9-6 , 19 59 , that I last saw the deceased alive on 9-6 , 19 59 , and that death occurred at 4,10 AM . ACTUAL SIGNATURE <i>John Kehoe</i>				ADDRESS (Street, city or town, state) 6300 Riverdale Road											
PHYSICIAN'S NAME (Type) Dr. John Kehoe, M.D.				DATE SIGNED 9/6/59											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>							

TRAIL TO ITALY

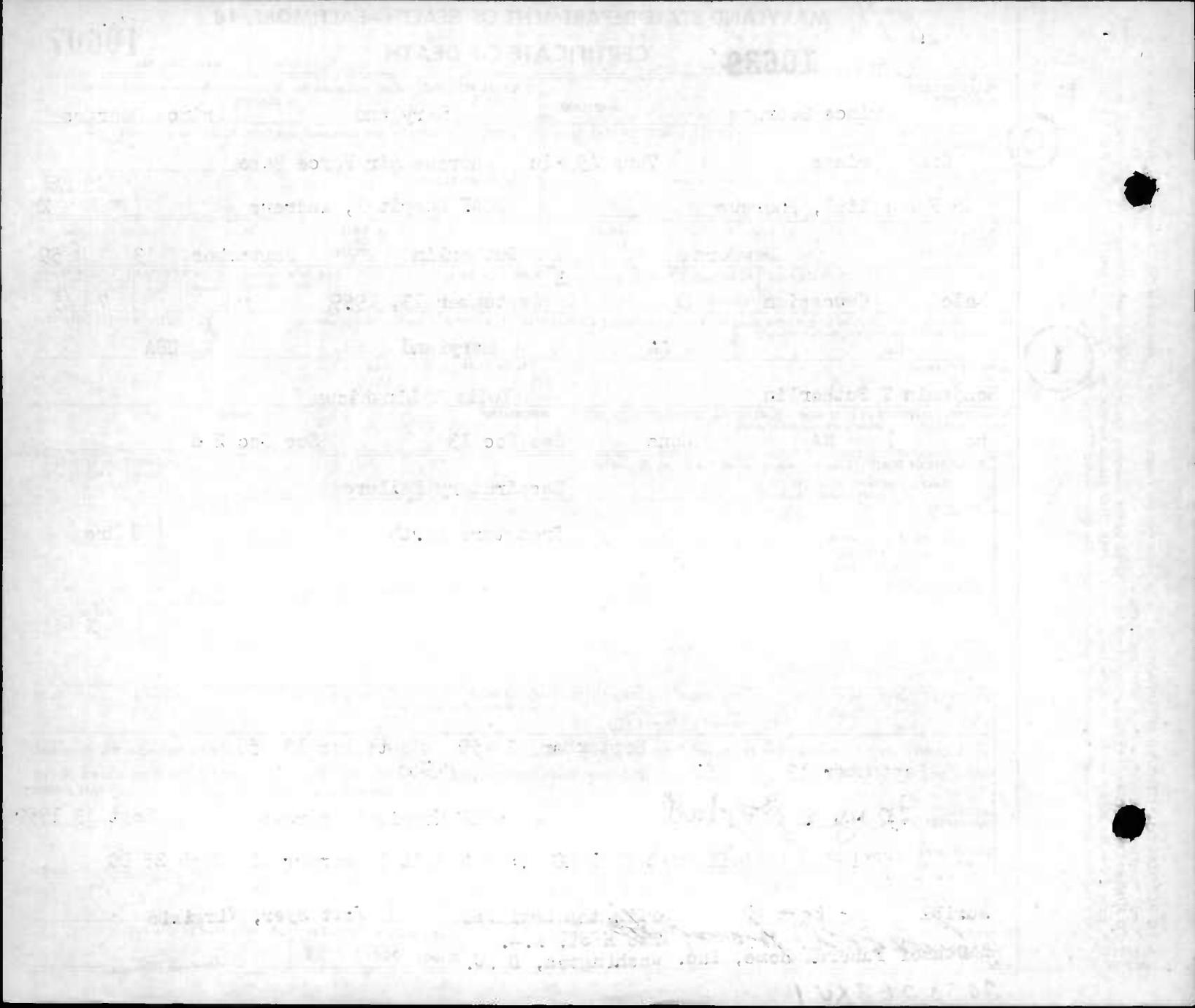
1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 10607			
CERTIFICATE OF DEATH 10639													
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN 1b 7hrs 45 Min			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital, Andrews					d. STREET ADDRESS USAF Hospital, Andrews					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NewBorn Benjamin		First	Middle	Last Sutherlin	4. DATE OF DEATH	Month September	Day 13	Year 19 59					
5. SEX Male		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH September 13, 1959	9. AGE (In years last birthday) yrs. 7	IF UNDER 1 YEAR Months 7		IF UNDER 24 HRS. Days 45 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA			10b. KIND OF BUSINESS OR INDUSTRY NA			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Benjamin T Sutherlin					14. MOTHER'S MAIDEN NAME Twila V Linthicum								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NA			INFORMANT See Sec 13		Address See Sec 2 d						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO Premature Birth 8 Hrs													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)			
21. I certify that I attended the deceased from September 13 1959, to September 13 1959, that I last saw the deceased alive on September 13, 1959, and that death occurred at 0500 M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) DATE SIGNED Sept 13 1959			
ACTUAL SIGNATURE George E Randall M.D. USAF Hospital Andrews													
PHYSICIAN'S NAME (Type) GEORGE E RANDALL Capt USAF MC USAF Hospital Andrews AFB Wash 25 DC													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 15 Sept 59		22c. NAME OF CEMETERY OR CREMATORI Arlington National			22d. LOCATION (City, town, or county) Fort Myer, Virginia			(State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 18 H St. N.E. Funeral Home, Inc. Washington, D.C.										24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE	
2050 263 XV 1										George E. Randall			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10609

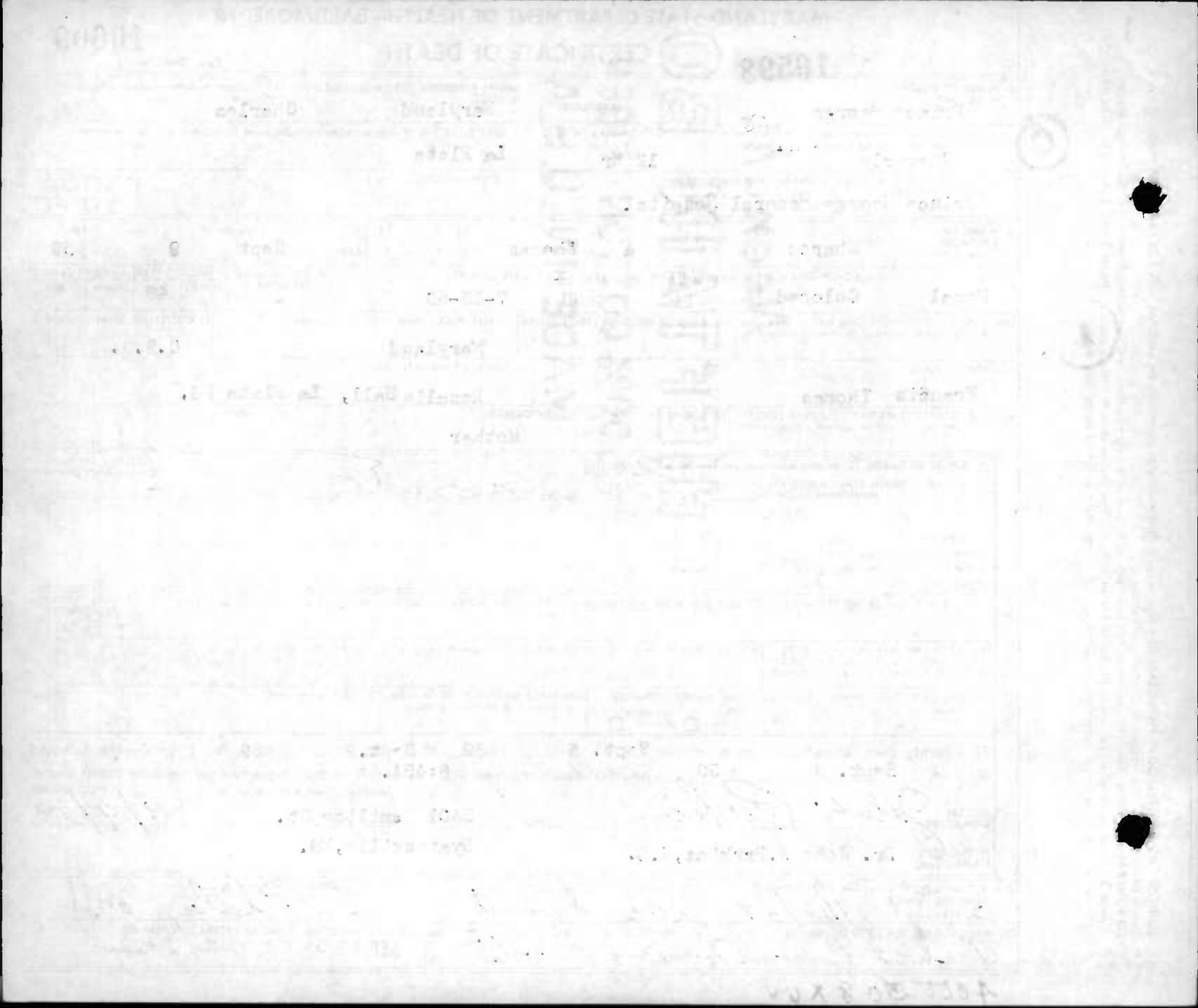
Reg. Dist. No.

10598

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		C. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 Hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		d. STREET ADDRESS 08X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sharon	Middle A	Last Thomas	4. DATE OF DEATH	Month Sept	Day 2	Year 1959
5. SEX Femal	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-59	9. AGE (In years lost birthday) - yrs. - 48	IF UNDER 1 YEAR Months 48	IF UNDER 24 HRS. Hours 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Thomas				14. MOTHER'S MAIDEN NAME Resalie Hall, La Plata Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Mother	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO _____ (c) _____							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 8 , 1959, to Sept. 9 , 1959, that I last saw the deceased alive on Sept. 9 , 1959, and that death occurred at 8:45 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED 9/9/59							
ACTUAL SIGNATURE <i>John W. Perkins</i>							
PHYSICIAN'S NAME (Type) Dr. John W. Perkins, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/10/59		22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart		22d. LOCATION (City, town, or county) (State) La Plata, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arhart Funeral Home, Inc. La Plata</i>		ADDRESS 4000 308 XUV		24a. REC'D BY REGISTRAR DATE SEP 11 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10610

10640

CERTIFICATE OF DEATH

Reg. Dist. No.

X TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
X may be retained by the hospital or attending physician and completely filled in by the funeral director.
X TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills		c. LENGTH OF STAY IN lb 4 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) b. INSTITUTION 5408½ Larry Ave., S.E.		e. STREET ADDRESS 5408½ Larry Ave., S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WALTER	Middle E.	Last TILGHMAN
4. DATE OF DEATH	Month Sept.	Day 8th.	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13- 1903
9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 56	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk	10b. KIND OF BUSINESS OR INDUSTRY Beef Supply Co.	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wycher C. Tilghman	14. MOTHER'S MAIDEN NAME Mary A. Simpson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. W.W. # 2.	INFORMANT Olive V. Tilghman (Same as # 2.)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Levotomy Thrombosis INTERVAL BETWEEN ONSET AND DEATH 5 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Levotomy DUE TO sclerosis (c) 5 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 15 , 19 46 , to Sept 8 , 19 59 , that I last saw the deceased alive on Sept 6 , 19 59 , and that death occurred at 3:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Fegan		ADDRESS (Street, city or town, state) 2210- Nichols Ave., S. E. Washington, DC.	
PHYSICIAN'S NAME (Type) JOHN B. FEGAN		DATE SIGNED Sept. 8th. 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept 10-59	22b. DATE THEREOF 1959	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery	22d. LOCATION (City, town, or county) Arlington, Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Jennings Bros	24a. REC'D BY REGISTRAR Arthur S. Evans	24b. REGISTRAR'S SIGNATURE Arthur S. Evans	
VS A15 (4) 15M 9/58			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10641

CERTIFICATE OF DEATH

10611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) QR INSTITUTION <i>DOA at. So. MD Hospital Center</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Popular Hills</i>	
3. NAME OF DECEASED (Type or print) <i>Ellis</i>		First <i>Elmer</i>	Middle <i>Temman</i>
3. NAME OF DECEASED (Type or print) <i>Ellis</i>		Last <i>Temman</i>	4. DATE OF DEATH Month <i>9</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Aug 27 1919</i>		9. AGE (In years last birthday) <i>40 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Freeman Electric Live Crew - Electrical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></i>	10c. IF UNDER 24 HRS. Days <i>0</i>
13. FATHER'S NAME <i>Claesce E Temman</i>		14. MOTHER'S MAIDEN NAME <i>Venice Watson</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-22-0018</i>	17. INFORMANT <i>Father</i>
18. MEDICAL CERTIFICATION PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i> DUE TO <i>cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>20 min.</i>	
		<i>cardiovascular accident</i> <i>1 hr</i>	
		<i>cardiovascular disease</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>JUNE</i> , 19 <i>46</i> , to <i>SEPT</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>SEPT 25</i> , 19 <i>59</i> , and that death occurred at <i>3:30</i> P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Alfred R. Lapin</i>		ADDRESS (Street, city or town, state) <i>Alfred R. Lapin, So. MD. Hospital Center, Clinton, Maryland.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-29-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Immanuel M.</i>
22d. LOCATION (City, town, or county) <i>Horsehead, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Walkley, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 30 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Lewis</i>

1501
PROTOSAURUS
MAGIC RO-STEAMER

33001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10599

CERTIFICATE OF DEATH

Reg. Dist. No.

10612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b	b. COUNTY Prince Geo. ✓	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brandywine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS Box 272 F	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Anita TURNER	First	Middle	Last	
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1958	
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) yrs. 1	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Doy 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
				12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Bernard TURNER		14. MOTHER'S MAIDEN NAME Ethreda Farmer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		INFORMANT Charles B. Turner, Brandywine, Md.
				Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053.4		onset during acute diarrhea		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____		Dental infection		
(c) _____ DUE TO _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-23, 1957, to 9-24, 1957, that I last saw the deceased alive on 9-24, 1957, and that death occurred at 6:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE (Signature)		Brandywine, MD 9-25-57		
PHYSICIAN'S NAME (Type) Richard K. Dobson		Brandywine, MD		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 9-26-59		22b. DATE THEREOF 9-26-59		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's
22d. LOCATION (City, town, or county) Bryntown		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS SEP 30 '59		24a. REC'D BY REGISTRAR
				24b. REGISTRAR'S SIGNATURE

12. 45 just ~~in~~ ~~in~~ ~~in~~ ~~in~~

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13. 45 ~~in~~ ~~in~~ ~~in~~ ~~in~~

long slender brownish yellow
with dark brownish yellow

14.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROOM (RURAL)		c. LENGTH OF STAY IN 1b NA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH	
d. STREET ADDRESS 1809 KENNY DRIVE		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DONALD		First JOHN	Middle WALKER
4. DATE OF DEATH SEPTEMBER 28 1959	Month SEPTEMBER	Day 28	Year 1959
S. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JULY 26, 1916
8. AGE (In years lost birthday) 43 yrs.	IF UNDER 1 YEAR Months 43	IF UNDER 24 HRS. Days 0	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARTHUR EARLEY WALKER		14. MOTHER'S MAIDEN NAME JULIA ALOISE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1941 TO DATE 577-01-1138	
17. INFORMANT OFFICIAL USAF PERSONNEL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 860x DUE TO BODY DISINTEGRATION INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO AIRCRAFT ACCIDENT (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY * PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AIRCRAFT CRASHED IN FLIGHT		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRCRAFT CRASHED IN FLIGHT	
20c. TIME OF INJURY Month, Day, Year Hour 8:50 p.m. SEP 28 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RURAL AREA	
20f. (City or town) CROOM		(County) PRINCE GEORGES MD.	
(State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:50P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS			
DATE SIGNED 29 SEP 59			
ACTUAL SIGNATURE Thomas G Briggs M.D.			
PHYSICIAN'S NAME (Type) THOMAS G BRIGGS CAPT USAF MC			
USAF HOSPITAL ANDREWS ANDREWS AFB 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 2, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Reed's Funeral Home, Inc.		ADDRESS 816 H St. NE DC	
24a. REC'D BY REGISTRAR OCT 2 1959		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

* SPECIAL STUDIES PERFORMED BY ARMED FORCES INSTITUTE OF PATHOLOGY

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TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10614

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hours		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION Prince George General				d. STREET ADDRESS 2217 University Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Sally	Middle	Last Walker	4. DATE OF DEATH Sept 1 1959	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1906	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mose Williams					14. MOTHER'S MAIDEN NAME Sylvia Stephens				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT George Thurman Walker, Husband,		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Rt. Internal Capsule and intraventricular)									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X									
(b) Essential Hypertension									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from alive on Sept. 1 1959 , and that death occurred 2:50P M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>William D. Rosson, M.D.</i>						ADDRESS (Street, city or town, state) 5304 Annapolis Road		DATE SIGNED Bladensburg, Maryland	
PHYSICIAN'S NAME (Type) Dr. William D. Rosson									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/59		22c. NAME OF CEMETERY OR CREMATORY Lincoln		22d. LOCATION (City, town, or county) Suitland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stewart</i>		ADDRESS 30-74 St. N.E.				24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur & Sons</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10615

Reg. Dist. No.

10601

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 4611 Lewis Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Calvin	Middle Charles	Last Walkling	4. DATE OF DEATH Sept. 12, 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-96	9. AGE (In years low birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver			10b. KIND OF BUSINESS OR INDUSTRY Transportation	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Walkling			14. MOTHER'S MAIDEN NAME Katherine Christ		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-46-8373		17. INFORMANT Lily M. Walkling; same address as # 2.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure					
DUE TO 443X					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease.					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney			DATE SIGNED Sept. 12, 1959		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/59		22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Gordon A. Mattingly		ADDRESS 1315 11th St. N.W.		24a. REC'D BY REGISTRAR DATE SEP 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Traub	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be rejoined for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY XXXX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3300 Block of Toledo Terrace				d. STREET ADDRESS 1428 Corcoran Street			
3. NAME OF DECEASED (Type or print)		First Aubrey	Middle	Last Walthall	4. DATE OF DEATH September 24	Month	Day
5. SEX Male		6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb-3-1927	9. AGE (In years last birthday) 32 yr.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Walthall				14. MOTHER'S MAIDEN NAME Florence Berkly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Doris Walthall 1061 Boston Rd.,		Address Bronx, N. Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 925.3 Suffocation INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compression of chest							
DUE TO (c) Cave-in of open ditch							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Working in open ditch when a side caved in covering deceased.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11.40 9-24- 159		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Apartment devel.		20f. (City or town) Adelphi	(County) Pr. Georges (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accidental <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 24, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sep-29-1959		22c. NAME OF CEMETERY OR CREMATORIUM Church Cemetery		22d. LOCATION (City, town, or county) (State) Charlotte Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.				ADDRESS 3015 12th St., NE		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

HTAGS TO STABILIZE HYDROGEN BONDS IN PROTEINS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10617

10602

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	c. LENGTH OF STAY IN 1b <i>46 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	b. COUNTY <i>Prince George</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>411 4th Street</i>	e. STREET ADDRESS <i>411 4th St</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Columbus Elwood Watkins</i>	First <i>Columbus</i>	Middle <i>Elwood</i>	Last <i>Watkins</i>		
4. DATE OF DEATH <i>September 29 1959</i>	Month <i>September</i>	Day <i>29</i>	Year <i>1959</i>		
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 31 1873</i>		
9. AGE (In years lost birthday) <i>86 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blacksmith</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>railroad</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Andrew Jackson Watkins</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth E. Brown</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Norman Watkins, Laurel, Md</i>	Address <i>—</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>480X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Influenza</i>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>—</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>9/27</i> , 19 <i>59</i> , to <i>9/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/29</i> , 19 <i>59</i> , and that death occurred at <i>210</i> P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>S. T. B. Steward</i>	ADDRESS (Street, city or town, state) <i>314 Constance Laurel, Md</i>		DATE SIGNED <i>9/30/59</i>		
PHYSICIAN'S NAME (Type) <i>N. B. Steward</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 1, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Particular Cem</i>	22d. LOCATION (City, town, or county) <i>Calverton Maryland Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Danedan, Laurel, Md</i>		ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE OCT 2 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur & Thomas</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10618

10618 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Prince George's County Maryland</i>		a. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL		<i>X Mitchellville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>Cora</i>	Middle <i></i>	Last <i>Watkins</i>	4. DATE OF DEATH <i>September 26 1959</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cal.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/23/1912</i>	9. AGE (in years lost birthday) <i>47 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
						<i>Md.</i>	
13. FATHER'S NAME <i>Harry Brooke</i>		14. MOTHER'S MAIDEN NAME <i>Cora J. Watson</i>		Address <i>Maud Jennings Mitchellville Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Artery occlusion myocardial infarction - minutes</i>		<i>1/2 to 2</i>	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Arteriosclerotic Heart Disease</i> (c) <i>generalized arteriolosclerosis</i>		years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from <i>9/14</i> , 1959, to <i>9/26</i> , 1959, that I last saw the deceased alive on <i>9/25</i> , 1959, and that death occurred at <i>8 p.m.</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>RFD Bowie Md</i>		DATE SIGNED <i>9/26/59</i>
ACTUAL SIGNATURE <i>H. James Ruytz</i>		M.D.		
PHYSICIAN'S NAME (Type) <i>H. James Ruytz</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/1/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Family</i>
				22d. LOCATION (City, town, or county) (State) <i>Woodmore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stewart</i>		ADDRESS <i>30-H St. NE</i>		24a. REC'D BY REGISTRAR <i>John T. Stewart</i>
				DATE <i>SEP 30 59</i>
				24b. REGISTRAR'S SIGNATURE <i>John T. Stewart</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1966 CERTIFICATE OF DEBT

BALTIMORE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10619

10545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aldie, Md.</i>	c. LENGTH OF STAY IN 1b <i>5 days</i>	b. COUNTY <i>Baltimore Co</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison 03 X-2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Our Lady's Home for Children</i>	d. STREET ADDRESS <i>Garrison Md</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i>	First <i>Elizabeth</i>	Middle <i>Parker</i>	Last <i>Welbourn</i>		
4. DATE OF DEATH <i>9 16 1959</i>	Month <i>9</i>	Day <i>16</i>	Year <i>1959</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27, 1959</i>		
9. AGE (In years lost birthday) <i>13 yrs.</i>	10. IF UNDER 1 YEAR <i>of 20</i>	11. IF UNDER 24 HRS. Monthly Days Hours Min. <i>21 S</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>realtor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>E. Hanbleton Welbourn</i>	14. MOTHER'S MAIDEN NAME <i>Nancy L Parker</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>NO</i>	17. INFORMANT <i>Holiday papers at Karsing Lane</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>internal hydrocephalus</i>					
DUE TO <i>752x</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>spina bifida</i>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>College Park, Maryland</i>	(County) <i>College Park</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>9/19</i> , 19 <i>59</i> , to <i>9/16</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/16</i> , 19 <i>59</i> , and that death occurred at <i>8:55</i> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>College Park, Maryland</i>	DATE SIGNED <i>9/16/59</i>
ACTUAL SIGNATURE <i>Thomas A. Christensen</i>	M.D.				
PHYSICIAN'S NAME (Type) <i>Thomas A. Christensen</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Funeral Services</i>	22b. DATE THEREOF <i>10/1/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Chesapeake Cemetery</i>	22d. LOCATION (City, town, or county) <i>Garrison 03 X-2</i>	(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stewart Monroe</i>	ADDRESS <i>108 W. North St.</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Times</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNNEN VERLAG - HEILIGE BIBEL DER KATHOLIKEN MIT PREDIGEN UND LEBENSBERICHEN VON KARDINAL JOSEPH Ratzinger

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10620

10603

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be removed and given to the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 1/2 Hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		d. STREET ADDRESS Box 235			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Julius		First	Middle	Last	4. DATE OF DEATH Sept. 19 1959	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1926	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 19	Hours 59	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (State or foreign country) Wash D.C.		12. CITIZEN OF WHAT COUNTRY? d.s.c.			
13. FATHER'S NAME Joseph Williams		14. MOTHER'S MAIDEN NAME Alice Culbreath							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WWII		INFORMANT Catherine Williams Wife		Address Add Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 hours 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic Cardiovascular disease (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 19, 1959 , to Sept. 19, 1959 that I last saw the deceased alive on Sept. 19, 1959 and that death occurred at 7:20 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE William D. Rosson, M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Road 91057		DATE SIGNED Bladensburg, Maryland					
PHYSICIAN'S NAME (Type) Dr. William D. Rosson, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-24-59		22b. DATE THEREOF 9-24-59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat		22d. LOCATION (City, town, or county) Arlington Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington 467 N st. N.W.		ADDRESS 467 N st. N.W.		24a. REC'D BY REGISTRAR SEP 24 '59		24b. REGISTRAR'S SIGNATURE Henry J. Washington			

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10604 CERTIFICATE OF DEATH

10621

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) b. STATE c. COUNTY	
<i>Prince Georges, Maryland</i>		<i>Maryland Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bladensburg</i>		<i>Bladensburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>4206-54th Place</i>		<i>4206-54th Place</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MIDDLE LAST	
<i>BESSIE</i>		<i>IONA WINTERS</i>	
4. DATE OF DEATH		Month Day Year	
<i>SEPT. 5 1959</i>			
5. SEX		6. COLOR OR RACE	
<i>Female</i>		<i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		<i>Jan. 10, 1885</i>	
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>USHER</i>		<i>THEATRE</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>HAW River, N.C.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>JOHN GAPPENS</i>		<i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
<i>NO</i>		<i>710-03-81948</i>	
17. INFORMANT		Address	
<i>John E. Winters</i>		<i>5404-5 Spring Road Bladensburg, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSETS AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>CORONARY THROMBOSIS</i>	
<i>420.1</i>		<i>1 Mils.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.		<i>Hypertensive Arteriosclerotic Cardiovascular Disease</i>	
DUE TO (b)		<i>Diabetes Mellitus</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>January 1959</i> to <i>Sept. 5, 1959</i> , that I last saw the deceased alive on <i>Sept 4, 1959</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>William D. Rosson</i>		DATE SIGNED <i>7/5/59</i>	
PHYSICIAN'S NAME (Type) <i>William D. Rosson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 8, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Suitland, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malley's Funeral Home</i>		ADDRESS <i>Int. Rainier, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Orlins & Kimes</i>	

CERTIFICATE OF DEATH

1000

MURKIN

MADE
NAMENO. 1000
NAME

REGISTRATION NO. 1000

NAME
BAPTISMALFATHER'S
NAME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10605

CERTIFICATE OF DEATH

10622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg</i>		c. LENGTH OF STAY IN 1b <i>12 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4206-54th Place</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Douglas</i>		First <i>W.</i>	Middle <i>Winters</i>
4. DATE OF DEATH <i>Sept 6, 1959</i>		Month <i>Sept</i>	Day <i>6</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <i>Feb 29, 1884</i>		9. AGE (In years lost birthday) <i>75 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Railroad - Pullman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	11. BIRTHPLACE (State or foreign country) <i>Old Hickory, Tenn.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>	
16. SOCIAL SECURITY NO. <i>1903-1906</i>		17. INFORMANT <i>John E. Winters - 5404 Spring Road Bladensburg, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177x</i>		Address <i>5404 Spring Road Bladensburg, Md.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Carcinoma of prostate.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
(c) DUE TO <i>Left renal obstruction, partial</i>		2 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 1959</i> to <i>Sept 6, 1959</i> , that I last saw the deceased alive on <i>Sept 5, 1959</i> , and that death occurred at <i>5 p.m.</i> from the cause and on the date stated above.		ADDRESS (Street, city or town, state) <i>5304 Spring Road Bladensburg, Maryland</i>	
ACTUAL SIGNATURE <i>William D. Rosson A.D.</i>		DATE SIGNED <i>Sept 11, 1959</i>	
PHYSICIAN'S NAME (Type) <i>William D. Rosson</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>Sept. 8, 1959</i>	22g. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home</i>		24a. ADDRESS <i>9200 - R.R. 1, Mt. Rainier, Md.</i>	24b. REC'D BY REGISTRAR DATE <i>SEP 9 '59</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur & Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10623

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cedar Heights		d. STREET ADDRESS 1106 64th Ave					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Ralph	Middle	Last	4. DATE OF DEATH	Month Sept. 21	Day	Year 1959				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitar		10b. KIND OF BUSINESS OR INDUSTRY Bldg		11. BIRTHPLACE (State or foreign country) Wash D C		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Ralph Warmly		14. MOTHER'S MAIDEN NAME Edna Knig									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		INFORMANT Obie Wormly, Wife		Address Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Accident DUE TO 33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2 days.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bladensburg, Maryland		(County) Muirkirk, Maryland	(State) Maryland		
21. I certify that I attended the deceased from Sept. 19, 1959 , to Sept. 21, 1959 , that I last saw the deceased alive on Sept. 21, 1959 , and that death occurred at 2:15 AM , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) William D. Rosson, 5304 Annapolis Road	DATE SIGNED 9/21/59		
ACTUAL SIGNATURE William D. Rosson		22a. BURIAL, CREMATION, REMOVAL (Specify) Sept. 25, 59 Carrier Memorial						22b. DATE THEREOF Sept. 25, 59		22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Muirkirk, Maryland	
PHYSICIAN'S NAME (Type) William D. Rosson		23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington & Sons						ADDRESS 467-71		24a. REC'D BY REGISTRAR DATE SEP 28 '59	
										24b. REGISTRAR'S SIGNATURE Carroll & Tamm	

STATE OF CALIFORNIA - DEPARTMENT OF REVENUE
CERTIFICATE OF DEATH

10000

DECEASED PERSON
NAME: MARY

STATION NUMBER

AGE: 5

DECEASED DATE

PLACE OF DEATH

REASON FOR DEATH

CAUSE OF DEATH

TIME OF DEATH

TIME OF DEATH

NAME OF DOCTOR

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF FUNERAL HOME

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10626

10607

CERTIFICATE OF DEATH

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.	
2		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.	
3		<p>1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 30 min 25 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital</p>	
4		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale</p>	
5		<p>3. NAME OF DECEASED First Elizabeth Middle A. Last Zinser 4. DATE OF DEATH Sept. 6 Month 19 Day 59 (Type or print)</p>	
6		<p>5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1902 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 19 Oct. 1955 9. AGE (In years lost birthday) 57 yrs. Months Days Hours Min.</p>	
7		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY At home 11. BIRTHPLACE (State or foreign country) Germany 12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
8		<p>13. FATHER'S NAME Joseph Hildenbrand 14. MOTHER'S MAIDEN NAME Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? No 16. SOCIAL SECURITY NO. None INFORMANT Ernest Zinser Address 4606 Rittenhouse Street, Riverdale, Md.</p>	
9		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriovenous Occlusion INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease. DUE TO (c)</p>	
10		<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>	
11		<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
12		<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>	
13		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
14		<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> p. m.</p>	
15		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville, Md. 20f. (City or town) (County) (State)</p>	
16		<p>21. I certify that I attended the deceased from 5-1, 1938, to 9-6, 1955 that I last saw the deceased alive on 9-5, 1957, and that death occurred at 12:45 A.M. from the causes and on the date stated above.</p>	
17		<p>ACTUAL SIGNATURE D. A. Deitz ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 9-6-57</p>	
18		<p>PHYSICIAN'S NAME (Type) Dr. A. Deitz, M.D.</p>	
19		<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-9-59 22c. NAME OF CEMETERY OR CREMATORIAL 3rd Lincoln Cemetery 22d. LOCATION (City, town, or county) Bladensburg, Md. (State)</p>	
20		<p>23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. ADDRESS 5801 Bladensburg Rd. 24a. REC'D BY REGISTRAR are. Riverdale Md. DATE SEP 9 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Turner</p>	

HTA 10 374217933

20001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, '58
10546 CERTIFICATE OF DEATH

Reg. Dist. No.

/10627

1. PLACE OF DEATH a. COUNTY		Prince George's MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Prince George's MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
HYATTSVILLE				HYATTSVILLE		HYATTSVILLE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		d. DATE OF DEATH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
8005-14th Ave.		8005-14th Ave., Hyattsville, Md		Sept. 13, 1959						
3. NAME OF DECEASED (Type or print)		First	Middle	Last	Month	Day	Year			
ANNA				ZOMBACK	Sept.	13	19 59			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
FEMALE		WHITE		SEPT 18 89	69 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
HOUSEWIFE					POLAND		U. S. A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME							
NACHMAN E. ZOMBACK			SARAH R. —							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO			—		JACK L. MELNICK		SPRINGFIELD VA. 5905 GRAYSON ST.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer</i> DUE TO <i>Rheumatic heart dis.</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>416X</i> DUE TO <i>Rheumatic heart dis.</i> 16 yrs (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19										
21. I certify that I attended the deceased from <i>Aug. 1959</i> to <i>Sept. 12, 1959</i> , that I last saw the deceased alive on <i>Sept. 8, 1959</i> , and that death occurred at <i>15th & M. St. N.W. D.C.</i> ADDRESS (Street, city or town, state)										
ACTUAL SIGNATURE <i>Adore Shulman</i> DATE SIGNED <i>9-13-59</i>										
PHYSICIAN'S NAME (Type) <i>ISADORE SHULMAN</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)		
BURIAL		SEPT. 14, 1959		KING DAVID MEMORIAL GARDEN		FALLS CHURCH		VA.		
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS					
B. DANZANSKY & Sons - 3501-14th St. N.W.					24a. REC'D BY REGISTRAR					
					DATE SEP 16 '59					
					24b. REGISTRAR'S SIGNATURE					
					<i>Arthur S. Krause</i>					

CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Name of Hospital

Address of Hospital

City of Hospital

State or Province

Country

Post Office

Zip Code

Phone Number

Fax Number

Email Address

Other

None

None